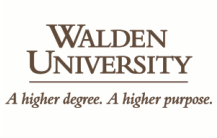

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Interprofessional Intentional Empathy Centered Care (IP-IECC) in Healthcare Practice

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Deepy Sur

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2019

Abstract

Interprofessional Intentional Empathy Centered Care (IP-IECC) in Healthcare Practice

by

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MSW, York University, 2006

BSW, Ryerson University, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

College of Social and Behavioral Sciences

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Abstract

Training interprofessional healthcare teams continues to advance practice for patient-centered care. Empathy research is also advancing and has been explored in social work, psychology, and other healthcare areas. In the absence of understanding empathy in an interprofessional setting, educators are limited in preparing teams to develop empathy as part of core competencies This grounded theory study explored for a theory of how interprofessional healthcare teams conceptualize and operationalize empathy in their practice. Azjen's theory of planned behavior and Barrett-Lennard's cyclical model of empathy framed the study. Data were collected using 6 focus groups and 24 semistructured interviews of varied healthcare professionals working in an interprofessional setting in Ontario, Canada. Systematic data analysis utilizing Auerbach and Silverstein's (2003) approach revealed participants engaged in and valued empathy as a team. Empathy was identified as purposeful and intentional behaviors believed to be meaningful for positive patient outcomes. In addition, professionals identified the role of genuine intent in the practice of empathy. As a result of this study, a grounded theory of interprofessional intentional empathy centered care explains the conceptualization and operationalization of empathy in practice. Collective empathy in an interprofessional team model contributes to improved patient outcomes. The work of this study ascertains that empathy is not accidental; it should be cultivated in the form of intentional and genuine team experiences. This study advances social change by further identifying how the practice of empathy can be integrated into interprofessional healthcare education and praxis.

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Dedication

This work is dedicated to the many patients and families who allow us in to their worlds to shape their healing journey. Within the confines of those inspirational moments I have learned about trust, tenacity, and genuine kindness. I also dedicate this to all the healthcare workers and angels of care who have worked with me, around me, and near me; your dedication never ceases to amaze me.

Acknowledgments

This work would have been impossible without the rich and meaningful learning moments with my doctoral Chair Dr. Barbara Benoliel, thank you for the interactions that developed my perseverance and ignited inspiration. I want to acknowledge my committee member Dr. Tracey Phillips for the insightful interactions and motivation, and URR, Dr. Alice Yick for her commitment to this work.

I am profoundly appreciative of the amazing women who throughout my lifetime have been my mentors and believed right alongside me. A special acknowledgement to my exquisite and fierce sisters whereby I first learned about empathy.

Thank you to my star Priya and my little bear Eisha for the courage it takes to gift mama time, patience, and unwavering love. Finally, dearest husband, my deepest gratitude for the many ways in which you shed light on my strengths, you are forever my superfriend.

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Chapter 1: Introduction to the Study

Introduction

Healthcare practice continues to evolve at a rapid pace, especially as the world continues to consider innovative strategies to help augment patient-centered care by fostering dynamic healthcare teams. Collaboration and teamwork in healthcare imply a shared responsibility and partnership to provide patient care (Kiosses, Karathanos, & Tatsioni, 2016). Researchers have developed frameworks to articulate the importance of practicing, teaching, and collaborative engagement in interprofessional settings (Canadian Interprofessional Health Collaborative [CIHC], 2010; Interprofessional Education Collaborative [IPEC], 2016). Interprofessional care includes delivery of health services by multiple team members from varying disciplines who work collaboratively (CIHC, 201; IPEC, 2016). While most frameworks and models indicated communication with each other and with patients as a crucial domain, I did not find the specific articulation of empathy and its description in interprofessional practice with patients. The aim of this study was to explore how interprofessional teams conceptualized and operationalized empathy in their work with patients and families in a healthcare setting.

Empathy research is advancing in academia and has been investigated in several social sciences, psychology, and healthcare areas. Empathy is the ability to understand and communicate an understanding of another person's perspective, and empathy is multifaceted, with cognitive, emotive, and behavioral factors (Han & Pappas, 2017). The literature reviewed for this study indicated that learning about empathy was an important part of training for healthcare professionals (Gerdes & Segal, 2009; Kiosses et al., 2016;

Zaleski, 2016). Researchers have associated empathetic care with several benefits: improved patient experience, an increased adherence to treatment recommendations, better clinical outcomes, fewer medical errors, and higher physician retention (Boissy et al., 2016). In addition, improved patient satisfaction due to communication skills can be attributed to empathic medical care (Boissy et al., 2016; Riess, 2017).

Empathy, teamwork, and an integrative approach to patient care bring about favorable patient outcomes (Hojat, Bianco, Mann, Massello, & Calabrese, 2015). Hojat et al. (2015) described an integrative approach as collaboration with other health professionals but also a deliberate desire to understand a holistic environment. Empathy and teamwork have common constructs. Researchers have examined the role of empathy in a clinical setting in a number of studies, citing it as a crucial component for building rapport and improving patient outcomes, as well as a key ingredient in communication style (Han & Pappas, 2017; Pedersen, 2009; Rahman, 2014; Riess, 2017).

Empathy plays a central interpersonal role in facilitating experience sharing and promoting a desirable therapeutic relationship (Riess, 2017). Promoting empathic capacity involves the consideration that it is more than an inborn trait; instead, empathy is a competency that can be taught and built in healthcare providers. Essentially, a basic feature is that empathy helps people connect (Riess, 2017; Watson, 2016). In social work specifically, Zaleski (2016) named empathy as an essential component of the therapeutic relationship; in fact, Zaleski expected that a practitioner possessed the ability to be empathic. Empathy also plays a key role in promoting experience sharing and positive rapport (Riess, 2017).

Learning about empathy is a vital part of training for healthcare professionals; in fact, researchers have noted the power of empathic care by citing improved patient experiences, better outcomes, and increased compliance (Boissy et al., 2016; Gerdes & Segal, 2009; Kiosses et al., 2016; Riess, 2017; Zaleski, 2016). Therefore, I discuss the role of empathy in healthcare, as well as influential empathy frameworks. In addition, I introduce the problem statement, purpose, and research questions in this chapter. This chapter includes a discussion of the guiding conceptual frameworks, assumptions, scope, and limitations. Finally, I review the significance of the proposed research in influencing social work practice, teamwork, and healthcare.

I did not find an extensive exploration of the relationship between empathy and interprofessional competency frameworks in the literature. With this study, I contributed to interprofessional competency development by explaining the role of empathy in the provision of interprofessional practice, as described by providers. In today's healthcare environment, interprofessional models of care have become all the more important in addressing the delivery of high quality care, promoting effective teamwork, and creating a well-prepared workforce of the future (Boissy et al., 2016; Riess, 2017; Sevin, Hale, Brown, & McAuley, 2016).

Background

In today's healthcare industry, organization leaders expect that providers will work in collaboration, in integrated teams, and find complementary ways to deliver patient-centered care (Sevin et al., 2016). A vision for interprofessional care has been supported by emerging frameworks for interprofessional education (IPE) and learning

(IPEC, 2016). Healthcare organization leaders have built infrastructures to promote and support team-based care delivery to acknowledge the need for innovative care models.

Interprofessional teams exist in a number of healthcare settings, such as in the provision of care related to chronic disease management, cancer care, palliative care, rehabilitation services, mental health, addictions work, and specialized care. In delivering healthcare, an effective team can influence patient outcomes positively (Babiker et al., 2014). In the evolution of healthcare, researchers have noted that teamwork is necessary to address comorbidities, complex care, and patient safety (Babiker et al., 2014; Sevin et al., 2016).

The framework for action on IPE and collaborative practice shows mechanisms that outline collaborative teamwork to help health policy makers implement IPE in their own areas (World Health Organization [WHO], 2010). Key messages emerging from their framework include that IPE is crucial to preparing healthcare teams of the future; although WHO (2010) noted communication as imperative, there was no specific mention of empathy.

The IPEC (2016) made significant contributions to the field of interprofessional practice and education by bringing together 15 national associations of schools of health professions to promote enhanced team-based care of patients and improved health outcomes. With what IPEC (2016) articulated as the *Triple Aim* (improved patient experience, improved health of populations, and reduced cost per capita of healthcare), they reaffirmed an interprofessional competency framework (IPEC, 2016). Desired principles, skills, and education strategies were integrated across the framework

characterized by four domains: values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork (IPEC, 2016).

In Canada, a similar movement in addressing interprofessional competencies occurred; the CIHC (2010) developed the National Interprofessional Competency Framework with six domains, including interprofessional communication, patient-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution (CIHC, 2010). The CIHC (2010) noted that interprofessional practice occurred when providers worked with people from within their own profession, with people outside of their profession, and with patients and families.

CIHC (2010) and IPEC (2016) endorsed the benefits of effective teamwork, including showing respect and building trust among team members to coordinate care for patients effectively. Interprofessional care refers to the provision of health services by multiple team members who work collaboratively; the benefits include improved outcomes and better communication (CIHC, 2010; IPEC, 2016). Implicit in foundational frameworks adopted by many organizations is effective communication style. For interprofessional care to be implemented successfully, everyone must work together to ensure the right environment is created.

One aspect of communication not explicitly named but implied in the key frameworks is the concept of *empathy*. Patients want to feel trust, connection, comfort, and respect (Boissy et al., 2016). Although there can be barriers to empathy, including comfort, time, and understanding, practitioners can be educated to provide better quality communication and care (Riess, 2017). Engaging patients with empathy can lead to

enhanced motivation, and in social work, empathy has been at the core of successful outcomes (Zaleski, 2016). Given that researchers described empathy based on affective, cognitive, and behavioral components (Barrett-Lennard, 1997; Riess, 2017; Zaleski, 2016), there was an opportunity for this study to converge dialogue with concepts of interprofessional competency frameworks.

Problem Statement

Patients now have more complex health needs and frequently require professionals from more than one discipline to address health outcomes. Interdisciplinary team work is a process where different types of staff work together to share expertise and skills to influence patient care (Nancarrow et al., 2013). Teams of varying professional backgrounds often collaborate to provide care; in some institutions, the concept of IPE has been introduced. IPE is a collaborative approach to develop healthcare providers who have knowledge of varying professional areas, team building, and patient-centered care in a team-based environment (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). I did not find research on the relationship between empathy and IPE.

In the absence of an understanding of the elements of empathy in a team-based environment, educators were limited in preparing teams to develop empathy as part of interprofessional competencies. The problem was teams were less prepared to deliver optimal care in high functioning environments. Because concepts taught in IPE prepared students for future interprofessional teams by teaching them skills for showing respect and positive attitudes toward others, and because patient outcomes could improve when team members have common skills, I explored the ways in which teams defined their

common empathic practices. Teams are increasingly expected to educate themselves on their practice together (Kiosses et al., 2016). I did not find a holistic theory for how empathy was described and conceptualized by interprofessional teams or how it was operationalized in a team-based environment; however, much of the literature I reviewed showed empathy as a contributor to increased positive clinical outcomes.

Purpose of the Study

In this study, I discovered and built a theory to explain empathy with patients and families in interprofessional healthcare teams. The purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Understanding the meaning of empathy in the provision of team-based care provided a basis for the formulation of a subsequent model to explain empathy as a teachable interprofessional competency. This constructivist grounded theory context-specific work contributes to improving clinical outcomes for patients and families; moreover, healthcare professionals who work together could apply the underpinnings to their care delivery.

Research Questions

The study was qualitative in nature, and the following were the research questions created to address the purpose of this study:

RQ1: How do interprofessional teams conceptualize empathy in their work with patients and families in a healthcare setting?

RQ2: How do interprofessional teams operationalize their practice of empathy in their work with patients and families?

RQ3: What are the elements and theory that describe empathy in interprofessional teams?

Conceptual Framework

The research was influenced and shaped by more than one conceptual framework: Barrett-Lennard's (1997) cyclical model of the phases of empathy and the constructs within Ajzen's (1991) theory of planned behavior (TPB) framework. Barrett-Lennard (1997) developed the model of empathy to acknowledge that a therapist began with listening openly, resonating what was heard, and expressing the resonance back, whereby the individual became aware of being understood. The model was based on Rogers's (1957) work on empathy and therapeutic relationships. Barrett-Lennard (1997) meant the model to be applicable to explaining empathy in the widespread population. The distinct steps in the model overlap and interlace, as characterized by empathetic attention, empathetic resonance, expressed empathy, and received empathy (Barrett-Lennard, 1986, 1997).

The TPB framework constructs could be used to acknowledge that attitudes, social norms, and perceived behavioral control influenced actual behavior or intention (Ajzen, 1991). As an extension of the theory of reasoned action, Ajzen (1991) suggested this framework explained that attitude toward a particular behavior, subjective norms, and perceived control could shape a person's intention. I contextually drew on the constructs of attitude, subjective norm, and predictive behavior. To meet the needs of this research study, both conceptual frameworks, as outlined by Barrett-Lennard (1997) and

Ajzen (1991), formed a basis for exploring the conceptualization and operationalization of empathy in a team-based setting; a deeper explanation is provided in Chapter 2.

Nature of Study

For this qualitative study, I implemented a grounded theory design. I considered an explanatory model using a grounded theory approach. Scholars have blended and synthesized theory to describe a new way of considering social issues, such as family violence and spirituality (Graf, Rea, & Barkley, 2013; Singh & Hira, 2017). I used a similar approach; grounded theory was characterized by the discovery of theory emerging from the data and analysis of relevant documents that were context specific (Auerbach & Silverstein, 2003).

Multiple data sources, including focus groups with interprofessionals and in-depth, semistructured interviews allowed me to validate concepts or new emerging terms. The approach indicated new insights, patterns, and relationships, as these pertained to improved patient care and empathic engagement (Ross & Watling, 2017). Therefore, grounded theory provided a means for examining data through interprofessional teams and empathy as a competency. This approach was best suited because of the scarcity of literature and lack of theory for this particular topic (Charmaz, 2006).

Definitions

I used the terms listed below throughout this study.

Constructivist grounded theory: The constructivist grounded theory refers to an inductive approach that considers that in human social science, there are multiple constructed realties that can be determined according to the view of the person

experiencing the situation and the researcher theorizing (Charmaz, 2006). Underlying this approach is the notion that researcher cannot be separate from the research, as it is through the researcher that insights emerge.

Grounded theory: The grounded theory is a process that delineates the discovery of substantive theory from an iterative process of data collection and analysis. The roots of grounded theory posit that the theory is developed from the data from which it was derived (Gehrels, 2013).

Interprofessional collaborative practice: For this study, interprofessional collaborative practice refers to when multiple health workers from different professional backgrounds work together with patients and families to deliver high quality care (WHO, 2010).

Interprofessional education (IPE): IPE occurs when individuals from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes (WHO, 2010).

Interprofessional practice: In this study, interprofessional practice encompasses the practice whereby different professional backgrounds provide services by working together and with patients and families to improve care (Ketcherside, Rhodes, Powelson, Cox, & Parker, 2017). IPEC (2016) described interprofessional practice as multiple health workers from different professional backgrounds working together with patients, families, care givers, and communities to deliver the highest quality of care.

Interprofessional team-based care: For this study, interprofessional team-based care is in reference to intentionally created groups in healthcare of providers who are

recognized as having a collective identity or shared responsibility for a patient or group of patients (IPEC, 2016).

Interprofessional teamwork: Interprofessional teamwork refers to the level of support, collaboration, and organization depicting the interactions among professions in providing care that is patient centered (IPEC, 2016).

Teaming: Edmondson (2014) described teaming as a process of bringing together skills as well as ideas from contrasting areas to produce something new. The concept of teaming denotes that no one individual can accomplish the task taken on by the team. Teamwork for this study is noted in the context of innovation, meaning it thrives when different disciplines and backgrounds come together to explore possibilities.

Assumptions

For this study, I assumed the participants were honest and forthcoming in their responses. I assumed participants were explicit in their answers, drew on their experiences, and met the criteria needed to participate. I also based this study on the assumption that using Barrett-Lennard's (1997) cyclical model of empathy and TPB as conceptual frameworks were appropriate and fitting. In addition, I assumed that a grounded theory method was appropriate for exploring the research questions, advancing knowledge, and developing a substantive theory. Finally, I postulated that by conducting focus groups and in-depth interviews, I achieved the right level of rich data for analysis and theory generation.

Scope and Delimitations

Boundaries for this study included data collection only from participants who worked in a team setting within a hospital or healthcare setting in the community. There was not any prescreening regarding previous experiences or personal details and health. I only pulled from the purposeful sample for both in-depth interviews and focus groups. A delimitation of this study was the exclusion of newly formed teams of less than 6 months, which was based on the notion that team rapport, norming, and forming was already established in teams working together for longer than 6 months.

Limitations

The first limitation of this study was the reliance on self-reported data gathered from participants. An additional limitation was that I found a lack of previous research on this topic. For the study I employed a qualitative grounded theory methodology, and I acknowledged that my biases might influence data analysis; I used a reflective and reflexive approach to address this issue. In conducting social science research, the worldview that I brought was characterized by constructivism. I sought to understand multiple participant meanings, social and historical constructions, and theory generation (Charmaz, 2006; Charmaz & Belgrave; 2012). I assumed individuals sought understanding of the world in which they lived and worked. Due to the nature of the study, the findings could not be generalized to the larger population.

As a practicing social worker, I had a particular interest in empathy as a practice and concept. I learned about empathy in my training; I believed that I practiced in an empathic manner. I learned these meanings were varied and multiple; the influence of my

practice meant I considered the complexity of views, as opposed to narrowing of ideas. In my practice, I often relied on client views, lived experiences, and an open-ended style of questioning to build my understanding. Similar to this, as a researcher, I listened carefully to what participants said or did in their settings and how their subjective meanings were socially negotiated. Team dynamics were of personal interest to my own practice; therefore, I explored the processes of interaction among individuals and teams.

Teams formed of less than 6 months were not included in this study to ensure participants had some baseline knowledge of one another's roles and responsibilities. The study was limited to teams in a healthcare setting, primarily hospitals and healthcare clinics in the community, because I believed this environment closely replicated the elements of a cross-functional team environment working with patients. The study findings were in the context in which the study was conducted; at best, the results might provide insights for substantive theory development. The results were not generalizable to the entire population. Existing confounding variables within the participant population could not be controlled.

Significance

Empathy is particularly important when considering how health professionals communicate with patients and families in the promotion, prevention, and treatment of disease, a significant competency defined by the IPEC (2016). The important skill of empathy for healthcare providers can drive, transform, and improve clinical outcomes. Discoveries from this work can advance the dialogue regarding holistic practice in team-based settings in healthcare.

Appreciating the existing meaning and significance of empathy as described by a variety of clinicians can illuminate the current understanding and application of empathy in teams. An awareness of empathy and its relationship to patient-centered care can positively influence healthcare costs, and ultimately advance social efforts that are focused on patient-centered care (Boissy et al., 2016). Conceptualization and operationalization of empathy in an interprofessional setting can also highlight necessary IPE teaching components and competencies. Future findings from my study would contribute to the field of social work by relaying the understanding of empathy and also its relationship to service delivery. Further, the basic meaning of my context specific study was to understand better how healthcare professionals, including social workers, could gain a greater understanding of the role of empathy and how it integrated into interprofessional care.

Summary

This study was framed to understand how interprofessional teams conceptualized and operationalized empathy in their work with patients and families in a healthcare setting. I explored the perceptions and experiences of team members from varying disciplines. In this chapter, I introduced the study by indicating the importance of empathy, as well as the significant presence of interprofessional teams in healthcare. Next, I described the relevant background to this study and gap in the research that I reviewed. I introduced the problem statement, which was concerned that in the absence of understanding how interprofessional teams conceptualized and operationalized

empathy in their work with patients and families, educators were limited in their teaching of empathy.

I provided the research questions and clarity of the central concepts for this study. I also explained the adopted framework for this study and provided rationale for choosing constructivist grounded theory as the qualitative frame. My assumptions relative to this study, along with the limitations and delimitations, were included. Chapter 2 consists of an extensive literature review, outlining previous research concerning empathy definitions, constructs, and its role in healthcare. In addition, the literature includes interprofessional team practice, competencies, and significance in healthcare.

Chapter 2: Literature Review

Introduction

Administrators have increasingly encouraged work teams to practice together in a holistic manner, particularly in healthcare (Riess, 2017). Concepts taught in IPE prepare students to collaborate in future interprofessional teams by teaching skills that show respect, positive attitudes toward others, and team connectivity (Ross & Watling, 2017). In a healthcare setting, teams often consist of pharmacists, physiotherapists, physicians, nurses, dietitians, nutritionists, specialists, quality improvement specialists, and social workers. The role of social workers, along with that of other professionals, must often be negotiated to demonstrate the unique value they add (Ambrose-Miller & Ashcroft, 2016).

Given emerging trends in patient-centered care, empathic skills are important for an entire team to cultivate (Zaleski, 2016). The purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Additionally, I sought to understand how interprofessional teams conceptualized and operationalized empathy in their work with patients and families. I did not find a model in the literature that specifically outlined the role and description of empathy in patient-centered care in interprofessional team care settings.

In this chapter, I provide the literature related to defining and understanding empathy, its role in healthcare, and constructs related to how it has been defined from the literature. The scope of this literature review includes IPE and practice competencies and their relationship to healthcare teams. I then synthesize literature related to clinical

outcomes of empathy, as well as outcomes related to interprofessional practice, including the role of social work in interprofessional care. In addition, this chapter includes a synthesis of relevant IPE constructs and the emergence of empathy theories.

Literature Search Strategy

I used a number of sources to conduct an online literature review, including the Walden University Library, Google Scholar, the World Wide Web, and the University of Toronto Library. I queried the following databases in full text: PsychINFO, SocINDEX, PubMed, Sage Premier, ProQuest Central, MEDLINE, and PsycARTICLES. The search was expanded to include ERIC and PsycTESTS. The search also included abstracts, dissertations, and theses from Walden University and ProQuest Dissertations and conference reports to garner a current and in-depth understanding.

To search for literature on empathy, literature on interprofessional teams in healthcare, and literature that linked both concepts, I used the following search terms and keywords individually and in conjunction: *interprofessional, interdisciplinary, multidisciplinary, multiprofessional, collaboration, education, training, competencies, empathy, empathic practice, patient centered care, theory, communication, theory of planned behavior, organizational theory, team-based care, healthcare, hospitals, collaboration,* and *empathy scale.* I used recent contributions to the field, except when reviewing seminal theories or older articles was pertinent to the study and no other recent contributions to the field were found.

Empathy in Healthcare

Through this study, I identified the need for a greater understanding of empathy in healthcare roles, including grasping the importance of empathy in healthcare and acknowledging the debate about the nature and definition of the concept of empathy. The sections that follow provide a review of the literature specific to definitions of empathy in healthcare, the significance of empathy in healthcare, empathy and clinical outcomes, and teaching empathy to healthcare providers.

Defining Empathy

The English term *empathy* is derived from the German word *Einfuhlungh*, a term from the practice of aesthetics, meaning to "feel into" an object. (Ross & Watling, 2017). In the field of mental health, Rogers's (1957) description of empathy was one of the most well-known; Rogers framed it as a person perceiving the internal frame of reference of another person with accuracy without ever losing the "as if" condition (Ross & Watling, 2017). In seminal works, Greenson (1960), Beres and Arlow (1974), Rogers (1957), Kohut (1982), and Zaleski (2016) explored empathy as an important factor for therapeutic relationships. Kohut (1982) built on Roger's (1957) seminal work and used empathy to describe a way of being with others to promote healing in psychotherapy (Watson, 2016).

Ross and Watling (2017) conducted an empirically based qualitative study and used constructivist grounded theory methodology to understand how psychiatrists used and understood empathetic engagement in practice. Results indicated three empathy elements: relational, transactional, and instrumental. In addition, empathy as a cognitive,

affective, and behavioral dimension was relevant in the study findings as an important frame (Ross & Watling, 2017). Empathy as a cognitive experience requires focus and intention, where an individual comprehends another's frame of reference but as separate from themselves (Riess, 2017; Ross & Watling, 2017). Larkin and Meneses (2015) described empathy as the experience of gaining insight into the experience of another, while understanding the experience as separate from their own. The cognitive aspect of empathy also adopts concepts of perspective taking in the provision of care.

Riess (2017), a physician in the Empathy and Relational Science Program at Harvard Medical School, reviewed empathy as a hardwired capacity in medicine and the critical role of neural networks in the capacity to be empathic. The affective and emotive nature of empathy, including perception and resonation, can be taught in medicine (Riess, 2017). Larkin and Meneses (2015) completed four in-depth case studies with 12 participants in their interpretive phenomenological study. The researchers revealed an example of resonation as a concept of feeling the effect of another and experiencing a congruent but not identical emotion (Larkin & Meneses, 2015).

In addition, empathy in healthcare has several qualities that are relational, transactional, and instrumental in nature. Empathy as a practice has the ability to understand and communicate understanding of another person's perspective (Larkin & Meneses, 2015; Riess, 2017). Relational empathy in healthcare occurs when the communication has happened effectively, such as when understanding and responding (Ross & Watling, 2017).

From a behavioral perspective, relationship building is central, and empathy can be an embodiment of identity, meaning, and communication (Gibbons, 2011). Barrett-Lennard (1985) presented the importance of empathy as an interpersonal process that could be intentional, automatic, verbal, or nonverbal in nature. Transactional empathy occurs when there is a need to negotiate aspects of care to find common ground, and empathy that is instrumental in nature happens when advanced skills are required to manage behaviors or complex reactions (Ross & Watling, 2017). The interpersonal nature of empathy had a range of qualities in practice and conceptualization; however, I did not find a commonly accepted description among social science professions, including social work and psychology. In addition, I did not find a common definition used among healthcare professionals who worked in a hospital or healthcare setting.

There yet remains a common definition of empathy across disciplines. While researchers had endorsed empathy as important within many professional standards, there was not a readily endorsed common classification. The National Association of Social Work did not include a definition of empathy in the Code of Ethics; however, empathy is listed in The Council on Social Work Education's (2008) *Accreditation Standards of Practice* (Section 2.1.10). Barker (2003) defined empathy as "the act of perceiving, understanding, experiencing, and responding to the emotional state and ideas of another person" (p. 141). Researchers have described empathy as a person understanding and sharing the feelings of another, putting the self "in another's shoes," sharing in emotion, validating a patient, and reflecting back an understanding (Hojat et al., 2015; Kiosses et al., 2016; Riess, 2017; Ross & Watling, 2017; Watson, 2016; Zaleski, 2016). In many

instances, the classification of empathy, as it compares to sympathy and compassion, has served as a defining concept. For example, Sinclair et al. (2017) investigated understandings and preferences of sympathy, empathy, and compassion in a cancer inpatient setting. Patients described each very uniquely. Empathy was experienced as an effective response that acknowledged the attempt to understand suffering through emotional meaning; this finding was different from sympathy, which was seen as a pity-based response, and compassion, which was seen as a containing enhanced facets of empathy, such as acts of kindness (Sinclair et al., 2017). Interestingly, Sinclair et al. (2017) noted compassion as the preferred response by patients.

Researchers have identified empathy as important for facilitating improved outcomes for both patients and physicians (Kiosses et al., 2016) and for those in other healthcare disciplines such as nurses, pharmacists, social workers, physiotherapists, and administrative staff (Riess, 2017). Despite this fact, empathy remains a difficult component to study and teach, especially because of debates around its definition and measurement. I did not find a widely accepted and endorsed common definition of empathy in healthcare, nor a shared definition of empathy in settings whereby varying disciplines practice together in a common clinical setting. However, the importance of empathy was identified, explored, and researched in a number of clinically focused domains.

Significance of Empathy

Researchers have examined the role of empathy in a clinical setting, citing it as a crucial component for building rapport and improving patient outcomes, as well as a key

ingredient in communication style (Babiker et al., 2014; Zaleski, 2016). Some concern has arisen over the growing detachment that providers can feel for patients over time, and researchers have referenced a decline of empathy in medical training and have noted the need to boost empathy training (Han & Pappas, 2017). Zaleski (2016) considered empathy an important part of a professional encounter and a clinical standard in ethical care. In delivering healthcare services, effective teamwork can positively influence patient safety and outcomes (Babiker et al., 2014).

Over the last several decades, interest in the role of empathy in psychotherapy has been continuously explored. This includes the ways in which "empathic practices" can be linked to therapeutic outcomes (Larkin & Meneses, 2015). As discussed earlier, Larkin and Meneses (2015) used in-depth case studies to reveal the experiences and meanings of interpersonal insights for people who experienced these, including how they made sense of these insights. Participants completed a survey characterized by interpersonal underpinnings and the researchers noted the significance of intuitive understanding as part of the paradigm of empathic relating with another. The literature that I reviewed indicated that promoting empathic capacity involved considering empathy as more than an inborn trait; rather, empathy was a competency that healthcare providers could develop (Riess, 2017; Watson, 2016).

Clients feel safe, heard, and supported when listened to empathically (Watson, 2016). Safety enables clients to focus their concerns and promotes exploration and awareness. In turn, empathic therapists can monitor their interactions because clinical empathy has been introduced in a number of healthcare curricula for its wonderful

attributes including dutifulness, moral reasoning, reduced malpractice litigation, improved history taking, physician satisfaction, improved therapeutic relationships, and overall positive clinical outcomes (Kiosses et al., 2016; Watson, 2016).

Levy, Shlomo, and Itzhaky (2014) explored whether therapists used empathy. In particular, Levy et al. examined empathy as part of social work graduates' professional identities in a qualitative study. The researchers surveyed 160 undergraduate social work students who were about to graduate. The authors noted the literature points to certain patterns of action that were directed to professional behaviors; one of these was values, which were the basis for developing basic skills such as empathy (Levy et al., 2014). Levy et al. linked professional identity among students to satisfaction with supervision, empathy, and social and personal values. These main components were linked to professional identity formation.

Empathy does extend beyond taking patients' medical history and symptoms. Empathy goes further than a clinical diagnosis and treatment, encompassing a connection and an understanding that includes affective, cognitive, and behavioral response (Barrett-Lennard, 2005; Larkin & Meneses, 2015; Riess, 2017). As a powerful communication tool, a provider can use empathy to build patient trust, improve health outcomes, and advance treatment adherence in social work practice (Mercer, 2002; Ross & Watling, 2017).

Despite a call for empathy in medical settings, little is known about the influence of empathy on the healthcare provider or on patient empowerment (Lelorain, Brédart, Dolbeault, & Sultan, 2012). Gibbons (2011) posed the construct of empathy as a central

factor in attitude, social neuroscience, and the value of empathic engagement noting the complexities of empathy practice. Lelorain et al. (2012) investigated the links between physicians' or nurses' empathy and patient outcomes in oncology in a systematic review of the associations of empathy measures and patient outcomes. Lelorain et al. associated clinician's empathy with higher patient satisfaction, better psychosocial adjustment, lesser psychological distress, and expressed need for information, particularly in studies with patient-reported measures and retrospective designs. Conversely, results indicated that empathy was not related to patient empowerment such as medical knowledge or coping (Lelorain et al., 2012). Despite this finding, Zaleski (2016) linked empathy in a clinical setting to positive outcomes, such as rapport and trust building.

Empathy and Clinical Outcomes

The role of empathy in a clinical setting has been examined in a number of research studies citing it as a crucial component for building rapport and improving patient outcomes, as well as a key ingredient in communication style (Han & Pappas, 2017; Pedersen, 2009; Rahman, 2014; Riess, 2017; Ross & Watling, 2017). In the medical literature, researchers have defined empathy as a desirable quality in doctors and correlated empathy with a better patient satisfaction, outcomes, and savings in time and expenses (Mercer, 2002; Ross & Watling, 2017).

Empathy is fundamental for interpersonal relationships and therapy (Larkin & Meneses, 2015). In a systematic review, Kiosses et al. (2016) described empathy as a cognitive attribute that related to understanding experiences of others, sometimes as an emotional state featuring sharing of feelings, and other times as a concept that was both

cognitive and emotional. For health professionals, patient communication is the mechanism to deliver care that is catered to emotional, cognitive, and biological needs. Kiosses et al. stated that in healthcare, healthcare workers could use empathy to understand the patients' situations, perspectives, and feelings, as well as to attach meanings, communicate that understanding, and check for accuracy with the patients directly.

Empathy plays a crucial interpersonal role in enabling sharing of experiences, needs and promotes positive relationships (Riess, 2017). Hojat et al. (2015) explored the overlap between the constructs of empathy, teamwork, and an integrative approach to patient care with 373 medical students who completed the Jefferson Scale of Empathy (JSE) amongst other scales. A significant overlap between the constructs was noted. Findings indicated implementing integrative patient care could improve empathic engagement in patient care and orientation toward teamwork.

Malin and Pos (2015) studied the impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. Symptoms for 30 depressed clients were assessed using a measure of expressed empathy. Empirical evidence indicated results consistent with therapist-expressed empathy positively predicting client reports of first session alliance, as well as therapist-expressed empathy directly predicted observer-rated deepened client emotional processing in the working phase of therapy (Malin & Pos, 2015).

Quaschning, Körner, and Wirtz (2013) explored shared decision making (SDM) as an approach for strengthening patient centeredness in medical rehabilitation. The aim

their work was to conduct a multicenter cross sectional study that included 11 inpatient rehabilitation clinics and 400 participants to test for a theory based model for the predictive power of empathy, team interaction, patient satisfaction, treatment acceptance, and SDM. SDM is a form of physician-patient interaction, which shares the process of decision making. Specific communication structures are required, which encourage mutual information exchange. The study was congruent with other findings; SDM was a direct predictor of patient satisfaction; moreover, Quaschning et al. noted empathy as a necessary component of patient centeredness and team interaction as an additional predictor for adherence and treatment acceptance.

Watson (2016) described and reviewed the role of empathy in psychotherapy and its history in research and practice. The researcher noted significant direct relationship between therapists' empathy and the outcomes at the end of psychotherapy. Watson associated a therapists' empathy with significant improvement in clients' reports of attachment insecurity and significant decreases in negative ways of treating the self. These negative ways included self-critical behaviors, silencing, and neglect at the end of therapy (Watson, 2016). Reductions on the Beck Depression Inventory, Inventory of Interpersonal Problems, Dysfunctional Attitudes Scale, and Rosenberg Self-Esteem Scale were also noted (Watson, 2016).

To understand empathy better and what factors can undermine and facilitate its experience, one must understand how it has been defined in the literature. One of the strong arguments for empathy in a healthcare setting is the strong connection between a good patient-practitioner relationship and positive outcomes (Riess, 2017). Researchers

have defined empathy as facilitating improved satisfaction in providers and patients (Hojat et al., 2015). Despite empathy being recognized as a crucial factor, it has remained difficult to study; therefore, examining literature that reviews empathy as a construct in healthcare is a critical component.

Empathy as a Construct

A noted challenge in empathy theory development is the absence of a shared definition of empathy; for example, Cuff, Brown, Taylor, and Howat (2016) reviewed empathy as a concept in the literature and found a wide variance. As early as 1909, researchers described empathy as "a process of humanizing objects, of reading or feeling ourselves into them" (Titchener, as cited in Cuff et al., 2016, p. 261). Then in 1949, Dymond (as cited in Cuff et al., 2016) defined empathy as "The imaginative transposing of oneself into the thinking, feeling and acting of another and so structuring the world as he does" (p. 127). More recently, Pelligra (as cited in Cuff et al., 2016) described empathy as "the ability to anticipate and share others' emotional states" (p. 170). Barnett and Mann (as cited in Cuff et al., 2016) noted the cognitive and emotional components of empathy in their expanded definition in 2013.

In their review of empathy directions, Bohart and Greenberg (1997) considered empathy in psychotherapy from the perspective of key contributors to the field. They noted a wide variety of views from contributors to the field in psychology and social work realms. A number of themes emerged, including client-centered, psychodynamic, experiential, cognitive-behavioral, and cross-cultural (Bohart & Greenberg, 1997). Their review led to a differentiation among three types of empathy: person, affective and

cognitive. Person empathy is an understanding of the whole person in situ, understanding what they have experienced including their histories and life stories, in essence, a holistic understanding. Affective empathy is being attuned to the affective experiences such as body language and narratives to understand clearly. Cognitive empathy is the capacity to understand and make sense of a client's narratives (Watson, 2016).

Bohart and Greenberg (1997) posited that psychotherapy was a multidimensional construct. When considering influencers in the field, they found a common construct of empathy included trying to sense, perceive, share, or conceptualize how another experiences the world (Bohart & Greenberg, 1997). Even still, different dimensions are involved, including cognitive, affective, action, a way of being together in relationship, and validation.

Researchers have defined empathy as one experiencing mood congruence, listening and interacting, and responding (Bohart & Greenberg, 1997). One dimension of importance is action and communication. This dimension is characterized by empathy as an attitude, and a basis for other therapeutic actions, as well as a way of being together (Bohart & Greenberg, 1997). Their review of other empathy literature indicated empathy involved a fundamental mode of interpersonal knowing and being together in experience. Therapeutic conditions also required validation to bolster positive regard for the client, grasp meaning, and respond genuinely (Bohart & Greenberg, 1997).

The Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1985) is a widely used client-rated measure of therapist empathy that assesses clients' perceptions of empathy, as operationalized by Carl Rogers (1957). Clients rate the extent to which

they experience the therapist as genuine or empathic during the therapy session (Barrett-Lennard, 1985; Malin & Pos, 2015). The BLRI is targeted to counselors and is a multidimensional model made up of 16 items. Self and patient versions have been created consisting of a 7-point scale. The questionnaire research instrument is an approach to studying the interpersonal relationships particularly of the helping nature, the instrument focuses on empathy, regard, and congruence.

In addition to skill building professions, including social work, could benefit from a stronger heuristic practice to convey empathy as a construct and as an experience in social work education (Gerdes, Segal, Jackson, & Mullins, 2011). Waves of research have suggested the benefits of empathic practitioners and many professions continue to explore mechanisms to cultivate empathy. To identify the best methods to develop, sustain, and ultimately teach empathy in healthcare settings there is a need to better understand the processes involved in empathic responses and the complexities of teaching it as a concept.

Teaching Empathy

Riess (2017) stated that as a capacity, empathy required an exquisite interplay of neural networks for one to perceive the emotions of others, resonate with others emotionally and cognitively, take in the perspective of others, and distinguish between one's own and others' emotions. In the past, empathy was considered an inborn trait that could not be taught, but research has shown that this vital human competency was mutable and can be taught to healthcare providers. Empathy is a complex capability enabling individuals to understand and feel the emotional states of others, resulting in

compassionate behavior. Empathy requires cognitive, emotional, behavioral, and moral capacities to understand and respond to the suffering of others. Researchers have demonstrated the evidence for patient-rated empathy improvement in physicians in pilot and retention studies (Riess, Kelley, Bailey, Konowitz, & Gray, 2010; Phillips, Lorie, Kelley, Gray, & Riess, 2013) and in a randomized controlled trial (Riess, Kelley, Bailey, Dunn, & Phillips, 2012). Further evidence that communication skills training for physicians improves patient satisfaction scores was reported in a large-scale observational study (Boissy et al., 2016).

Rahman (2014) noted that as a practicing oncologist of over 35 years, he witnessed the growing importance of teaching students medical humanities as early as possible. Rahman (2014) commented that teaching should become a standard part of curriculum, a belief that only increased after he became a patient himself. Rahman conducted a systematic review of empathy-enhancing educational interventions in undergraduate medical education; with 18 articles reviewed, he suggested educational interventions could be effective in enhancing empathy. Of note, conceptual clarity of empathy was a limiting factor amongst many articles (Batt-Rawden, Chisolm, Anton, & Flickinger, 2013). Batt-Rawden et al. (2013) found in at least four articles that when cognitive empathy was targeted with communication skills training, a positive trend in the better The Jefferson Scale of Physician Empathy (JSPE) scores was noted, suggesting empathy as a skill could be modified.

In their study that explored a theory to explain how psychiatrists used empathy in daily practice, Ross and Watling (2017) interviewed academic and resident psychiatrists

and posed a theory of empathetic engagement. The elements included relational, transactional, and instrumental empathy. Their work was beyond the scope of teaching empathy; however, the theory could contribute to the discussion and teaching of situational empathy and provided a language in which to discuss how empathy was used in settings (Ross & Watling, 2017). Social work schools are often charged with ensuring students understand and practice empathy, particularly with mental health and hard to reach clients, yet few school leaders have explored the challenges to enhancing empathy related skills (Zaleski, 2016).

In a meta-analysis that examined the efficacy of empathy training in randomized controlled trials, Teding van Berkhout and Malouff (2016) defined empathy as understanding the emotions another was feeling, feeling the same emotions as another, or commenting accurately on the emotions being felt by another person. The authors examined cognitive, affective, and behavioral targeted empathy training. A variety of training methods were offered, including experiential, didactic, skills, and mixed. The authors noted of the 18 studies with a total of 1,018 participants, a medium effect (g = 0.63) of empathy training was demonstrated. Findings pointed to empathy training as effective, and future research warranted an exploration of the training conditions and different types of healthcare trainees, including social workers.

Kiosses et al. (2016) confirmed in their systematic case review that empathy is indeed an attribute that is amenable to change due to educational experiences. To develop an education setting for promoting empathy, future work needs to take into consideration

that the extent to which empathy can be actualized or enhanced. Unfortunately, few theories link teaching and learning methodologies to empathy.

A targeted social work framework for empathy rooted in interdisciplinary context emphasizes implementable components for social work educators was suggested by Gerdes et al. (2011). Gerdes et al. posited students could understand the basic process of neural pathways that determined affective empathic responses, thereby developing cognitive empathic abilities. The framework indicated that knowledge, values, and skills that were informed by empathy could influence acting consciously.

Existing theories generalize about the influences on empathy as a practice capacity (Coplan, 2011). There are some practical approaches to teaching empathy that have been noted, but it has been particularly difficult to measure the effectiveness of these especially because of the lack of clarity and unity in the literature around empathy as a construct. Kiosses et al. (2016) introduced empathy in patient care as a complex construct involving at least three factors: (a) perspective taking, (b) compassionate care, and (c) standing in the patient's shoes. These concepts had some resemblance with expectations for interprofessional practice and care, including communication.

Interprofessional Competencies in Healthcare

Interprofessionalism, collaborative practice, and team-based care is the practice of working with practitioners from different disciplines, including non-health professionals, and often includes patients and families in the delivery of care (Harris et al., 2016; Ketcherside et al., 2017). IPE occurs individuals from two or more professions learn about, from and with each other to enable effective collaboration and improve health

outcomes, the IPEC (2016) noted the holistic components of preparing professionals through interdisciplinary education (WHO, 2010). The sections that follow provide a review of the literature specific to interprofessional competencies, theoretical influences on interprofessional practice, interprofessional teams in healthcare, and healthcare teams of the future.

Interprofessional Practice and Competencies

A number of terms are used in the literature to describe collaborative work between various professionals including interdisciplinary, interprofessional, multiprofessional, and multidisciplinary (Nancarrow et al., 2013). The terms are often intermixed and interchanged along with concepts of team work. The term interprofessional can be used to describe teams exclusively of professionals from different disciplines and their relationships to one another, while interprofessionalism, interprofessional collaborative patient centered practice, and team based care can be used to describe the practice of work (Ketcherside et al., 2017; Nancarrow et al., 2013). Interprofessional practice is a collaborative practice occurs when healthcare providers work with other disciplines to provide healthcare to patients and families, this is often important for prevention of disease, improving health, and providing cost effective care (Harris et al., 2016). The concept of interprofessional practice is important because the literature underscores the importance of socializing healthcare providers to working together for shared problem solving and decision making toward enhancing the benefit for patients (Bader & Jaeger, 2014; Centre for Advancement in Interprofessional Education, 2002; CIHC, 2010; Ketcherside et al., 2017).

The WHO (2010) described IPE as "when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (p. 13). Further to this description, WHO (2010) described collaborative practice as "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (p. 13). As the delivery of healthcare evolves to become more interconnected, coordinating care between providers has become important in ensuring improved patient outcomes (WHO, 2010). IPEC (2016) described interprofessional practice as the degree by which clinical staff from various backgrounds worked jointly with clients to provide high quality care.

Healthcare teams are becoming increasingly more interprofessional meaning they are moving toward health professionals from different disciplines working together in a sophisticated manner to improve care delivery (Ketcherside et al., 2017). Coordinated care has been influenced by re-organized systems of care that improve patient outcomes, reduce healthcare costs, and enhance adherence (Quaschning et al., 2013). This type of team work has also been shown to provide benefits to healthcare providers including job satisfaction and shared responsibilities (Bosch & Mansell, 2015).

In the United States, the IPEC (2016) released *Core Competencies for Interprofessional Collaborative Practice* after six national associations of schools of health professions formed a collaborative to encourage interprofessional learning opportunities. The core competencies have been broadly shared since first publication in

2011. In 2016, the document was updated with an expanded membership and meaningful changes to the established domains.

The four core competencies and subcompetencies are characterized by a number of principles some of which included patient centered, community and population oriented, relationship focused, process oriented, linked to learning, educational strategies, and outcome driven. Four main competencies were identified, including values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams/teamwork (IPEC, 2016). To create high functioning interprofessional teams, it is advantageous to start with how participants are trained. Historically in the case of health professionals, this has typically occurred in isolation with little efforts to integrate content or the process of training across disciplines (Nelson, Hodges, & Tassone, 2014).

Similar to IPEC (2016), the CIHC (2010) acknowledged the goal of interprofessional practice as helping to improve health outcomes for those using the health system. Further to this the Canadian Collaborative Mental Health Initiative (CCMHI) described four elements of collaborative mental health consistent with IPEC (2016), including (a) increasing accessibility to mental health services, (b) consumer centeredness, (c) the need for systems and structures to support collaboration, and (d) enhancing the richness of collaboration (Gagne, 2005). A number of factors, including communication and enhanced teamwork, are consistent in the competencies.

Empathy, teamwork and integrative approaches to patient care can contribute to patient outcomes, a common denominator amongst these is interpersonal skills. Interpersonal skills also include understanding patient views and an integrative approach

to patient care requires collaborative relationships with other healthcare professionals and also an effort to better understand holistic treatment (Hojat et al., 2015). Nestor (2016) recognized that interprofessional teams and shared values addressed barriers and moved fragmented care into integrated care. Interprofessional teams who leverage information, experience, communication, technology, and embrace a culture of teamwork provide increased value for patients and families (Hojat et al., 2015; Nester, 2016). Therefore, one must consider the importance of collaboration in interprofessional care delivery.

Researchers have viewed collaboration of various healthcare professionals within a team as an important factor for effective and efficient healthcare (Bower, 2003; Lemieux-Charles et al., 2006; Quaschning et al., 2013; Schmitt, 2001). Thoughtful communication and interactions in a team are associated with improved treatment outcomes, reduction of morbidity, increased patient satisfaction, employee satisfaction, reduced healthcare costs (Quaschning et al., 2013). Hutchison (2016) described interdisciplinarity as the act of combining two or more academic disciplines into one activity, adding that interdisciplinarity not only taught one what to learn but also how to learn the information.

Despite a growth in the attention to IPE and interprofessional practice initiatives, many have not been informed or guided by the use of theory (Thistlethwaite, 2011).) Interprofessional practice has been increasingly exposed to the use of social, psychological, and educational theories as an opportunity to frame the field (Suter et al., 2013). More modernly new insights have demonstrated the use of organizational theories in healthcare practice and teams (Suter et al., 2013).

Organizational theories have been used in interprofessional fields include institutional theory (DiMaggio & Powell, 1991); learning organization theory (Senge, 2014); and systems theories, such as activity, chaos, and complexity theories (Cooper, Braye, & Geyer, 2004; Engestrom, Engestrom, & Vahaaho, 1999; Krippner, 1994).

Systems and organizational theorists build on the premise that organizations consist of multiple and interdependent parts that collectively form a number of interactions that are greater than the sum of the parts (Berta et al., 2015; Suter et al., 2013). Researchers have used many systems theories in healthcare research (Brannon, Kemper, & Barry, 2009; Crabtree et al., 2011; Suter et al., 2013).

Organizational learning theory bares resemblance to systems theory in that it considers a holistic view of organization including individual and group dynamics, power, communication, culture, information networks, and behaviors (Berta et al., 2015; Reynolds-Kueny, Toomey, Pole, & Hinyard, 2017; Suter et al., 2013). The theory is situated on the notion that organizations can acquire, reflect upon, and analyze knowledge throughout the organization while continuing to adapt the processes (Reynolds-Kueny et al., 2017). Organizational theories can be helpful in settings especially where cultures of silence can further hinder patient care and outcomes; in fact, these theories have driven healthcare institutions to become learning organizations (Dankoski, Bickel, & Gusic, 2014; Maxfield, Grenny, & Groah, 2011; Reynolds-Kueny et al., 2017).

Interprofessional teams in healthcare are comprised of multiple health disciplines with diverse knowledge, and skills coming together to coordinate and drive goals

centered on optimizing quality outcomes for patients and families (Bader & Jaeger, 2014; Paradis & Whitehead, 2015). The intention is to foster a healthy work environment and promote a set of competencies toward a common goal. Positive evidence of interprofessional practice, such as in chronic disease and mental health, has influenced the emergence of enhanced team work (Virani, 2012). One must review the materialization of interprofessionalism in health services.

Interprofessional Teams in Healthcare

Research suggests high functioning interdisciplinary teams have a number of characteristics in common including positive leadership, positive team environment, clear vision, skills mix, and respect for roles (Bader & Jaeger, 2014). Bader and Jaeger (2014) interviewed an interdisciplinary team of occupational therapists, nurses, and social workers providing services for persons with HIV/AIDS. The in-depth research, accompanied by a comprehensive literature review, indicated some common characteristics among the team, including a connectivity to the organizations vision and compassionate communication.

A meaningful team mission statement can prove inspirational for providers along with offering clarity and guidance for decision making. Providers then have the opportunity to examine how their day-to-day work supports the overall mission. Teams should be further encouraged to identify how the team contributes to, identifies with, and translates the mission as an opportunity for inspiration (Bader & Jaeger, 2014; Nancarrow et al., 2013).

Literature on interdisciplinary teamwork notes the importance of communication particularly around sharing of client information. This included communication with empathy in a manner that fosters listening to another perspective, without interruption, genuinely. Teams that communicate well with one another, provide a similar understanding through empathic communication with clients (Bader & Jaeger, 2014). Compassionate communication is described as a style that focuses on one's own experience, empathy for others experience, and authenticity and respect.

The make-up and structure of an interdisciplinary or interprofessional team should include equality, nonhierarchical reporting, and problem solving skills (Bader & Jaeger, 2014). After a review of research, Moyers and Miller (2012) noted that regardless of theoretical basis, high-empathy practice improved client success rates. The researchers proposed that an emphasis on empathic listening skills in training therapists improved outcomes.

If interprofessional teams can have a positive effect on patient satisfaction, patient adherence to treatment, improved health outcomes, professional satisfaction, and sustaining quality care (Bader & Jaeger, 2014; Moyers and Miller, 2012; Nancarrow et al., 2013; Paradis & Whitehead, 2015) then one could surmise that healthcare investments might focus on interprofessionalism. Interprofessional healthcare delivery models are emerging as preferred method to provide coordinated, cost effective, and high quality healthcare for patients. With more organizations establishing these models, one must understand the future state context.

Healthcare Teams of the Future

Nancarrow et al. (2013) combined a review of the literature with over 200 practitioner perspectives to develop competencies to describe high-functioning interprofessional teams. Interprofessional team work was built into literature conversations about team work and outcomes. Nancarrow et al. (2013) posited interdisciplinary team work was a process where staff shared expertise, knowledge, and skills in their work with patient care. The characteristics included positive leadership, management attributes, communication strategies, personal rewards, training and development, appropriate resources, skill mix, supportive climate, clarity of vision, quality of outcomes of care, respecting roles, and individual characteristics that support interdisciplinary work. The 10 competency statements signified the necessary elements of a high functioning team.

Healthcare teams of the future should not only address complex issues and patient management but also acknowledge the importance of connectivity to mission, structure, time, and compassionate communication (Bader & Jaeger, 2014). Simon Sinek (2009) explored the concept of connectivity to day-to-day work. In his *Ted Talks*, Simon Sinek (2009) presented a model for how leaders inspire action, he coded this as the golden circle, including "why," "how," and "what." He focused on the concept of "why" as the purpose that comes from within. He noted people did business with others who believed in their work, and on a deep level, people must believe that their work is valued.

While many practical benefits of interprofessional practice were named in the literature, interprofessional practice, education, and concepts could pose the potential for

barriers. The availability of diverse language to contribute to the field was bewildering, as one could use interprofessional, multiprofessional, and interdisciplinary interchangeably without general agreement (Bader & Jaeger, 2014). Paradis and Whitehead (2015) explored the historical emergence of the field of IPE and noted that while publications regarding IPE have grown in the past decade, there was a lack of attention to power and conflict. Many IPE frameworks pay reduced attention to structural, organizational, and institutional factors that act as barriers to IPE (Paradis & Whitehead, 2015).

Baker, Egan-Lee, Martimianakis, and Reeves (2010) considered IPE a key mechanism in increasing communication and practice among providers, optimizing participation and improving the delivery of care. Even still, an under-explored factor connected to this was the unequal power relations that existed between the health and the social care professions (Baker et al., 2010).

In a focus group of Canadian social work educators, practitioners, and students to detect barriers to collaboration, researchers noted six themes (Ambrose-Miller & Ashcroft, 2016). These themes included culture, self-identify, role clarification, decision making, communication, and power dynamics (Ambrose-Miller & Ashcroft, 2016). Even though there was an increasing trend to interprofessional models, many areas of power had limited exploration.

Ambrose-Miller and Ashcroft (2016) discussed the importance of the work of social workers in interprofessional collaboration, noting the importance of roles and responsibilities. While the roles of the social worker can be identified by the goals of the

organization, social workers can influence practice by carving the unique qualities they bring to the table including conceptualizing the debate about medical models versus anti-oppressive frameworks (Ambrose-Miller & Ashcroft, 2016). Governing bodies, such as the National Association of Social Workers (n.d.) and Canadian Association of Social Workers (n.d.), acknowledged the critical role of social work, as healthcare delivery teams expanded to embrace interprofessional models. Crucial to the role of social work in these settings was the awareness of social work contributions, diversity, and the value that social workers brought by adding a different conceptualization and approach to health (Ambrose-Miller & Ashcroft, 2016).

Researchers have acknowledged collaboration as an essential component of team process. Researchers have defined collaboration as a process that requires competence, confidence, and commitment on the part of all (Bader & Jaeger, 2014; Nancarrow et al., 2013). Key ingredients include respect, trust, and patience and nurturing (Nancarrow et al., 2013; Quaschning et al., 2013). The concept of patient care within a team setting involves exploration of environment, roles, and communication style (e.g., empathy).

Conceptual Frameworks

Empathy involves the most basic aspects of person perception, enhanced interpersonal functioning, and complex forms of interpersonal understanding (Bohart & Greenberg, 1997; Ross & Watling, 2017). Several theorists in the literature showed the importance of communication as a fundamental concept and empathy as a relationship building necessity (Watson, 2016; Zaleski, 2016). However, I found that the theories did not focus on empathy in a team setting. More than one conceptual framework was

explored for this research study. The constructs of empathy were important to this research and influenced this work. Barrett-Lennard's (1985) cyclical model of the phases of empathy framed this study; in addition, this research was informed by the constructs within the TPB framework, which showed the relationship between conceptualization and practice.

Based on Carl Rogers' (1957) work on empathy in therapy relationships, Barrett-Lennard (1997) described empathy as a cycle in which a therapist listened openly, resonated, then expressed the resonance back, and the patient became aware of being understood (Ross & Watling, 2017). In his seminal work, Barrett-Lennard (1997) explored empathy as a crucial feature of client change and posited an impairment of empathy for others could be an effect and cause of suffering for the person seeking help. Interpersonal empathy is explained by Barret-Lennard's (1997) cyclical outline of the empathy cycle (Godfrey, 1981). He noted interpersonal empathy depended on a cycle of processes, including (a) actively attending with an empathic set, such as being attentive in a special way including a desire to know; (b) expressing an empathic response whereby a person must convey that they understand the other person; (c) expressing empathy makes it possible for the other person to receive the empathy; and (d) repeating this cycle.

Since then, Barrett-Lennard (2005) positioned his framework to state that relationships were central to developing psychological health and well-being. He later developed a framework to incorporate nine different systems of relation in which human existence was embodied. The systems, which could be interconnected, included the

individual, primary two-person relationships of the person, family system, small groups, large groups, communities of belonging, states, human race, and planetary life systems.

The relationship between behavioral intentions and actual behavior has been studied in the context of conceptual and operational comparison. The specific nature of the relationship between beliefs and attitudes has been evaluated in the context of key constructs named by Ajzen (1991). Ajzen (1991) proposed TPB as an extension of the theory of reasoned action (Ajzen & Fishbein, 1980). The TPB incorporates elements from learning theory, particularly the sentiment that overt behavior does not fall from attitudes but is reinforced through a learning process (Eisman, 1955). Ajzen (1991, 2005, 2011) developed the TBP as an explanatory model to be widely applied in studies on behavioral intention (Ajzen & Fishbein, 1980; Lee, Cerreto, & Lee, 2010). One could use the TPB framework to posit that planned behavior was a function of the intention to act and perceived behavioral control; meaning, the intention to act was a function of attitudes. The theory was in some ways intended to explain behaviors over which people have the ability to exert self-control (Glasman & Albarracin, 2006).

Ajzen (1991) developed the TBP framework to note the importance of relating attitudes, social norms, and perceived behavioral control to actual behavior or intention in decision making. The TPB is the most used framework amongst behavioral models (Caplescu, 2014). The TPB is not discipline-specific and merits the ability to define the variables to be used within a macro level context even though it is a micro model (Caplescu, 2014). The framework is an extension of the theory of reasoned action and combines means of assessing intent and action. The TPB constructs are characterized by

the notion that attitudes toward a behavior are assumed to be based on behavioral beliefs (Ajzen, 1991, 2005; Heuer & Kolvereid, 2014).

The TPB framework is built on a few key constructs. The first construct is the attitude toward an act or behavior meaning a person's belief of whether a particular behavior or act makes a positive or negative contribution to their life (Ajzen, 2005; Wenhold & White, 2017). The second construct is named subjective norm, focusing on everything around the person including their social network, group beliefs, and cultural norms. The third construct is named perceived behavioral control referring to how easy or difficult a person believes it is to display a certain behavior or act (Ajzen, 2005; Wenhold & White, 2017).

Researchers have demonstrated the application of the TPB constructs as a model or framework when considering favorable consumer trends and decision making in education, parenting, and health (Ajzen, 2011; Caplescu, 2014; Lee et al., 2010; McMorrow, DeCleene Huber, & Wiley, 2017; Wenhold & White, 2017). The TPB is a social cognitive model of the influences on an individual's decision to engage in a particular behavior.

McMorrow et al. (2017) outlined the implementation process for IPE in Faculty Learning Communities (FLC); the outcomes from a qualitative evaluation 18 months after completion indicated capacity building opportunities. Interestingly, findings included faculty who noted an openness to IPE because of participation in a FLC. McMorrow et al. commented that this attitudinal change could be a precursor of behavior

change, citing constructs from Ajzen's (1991) TBP model for explaining behavior (McMorrow et al., 2017).

Researchers have challenged the TPB for its continued applicability. Sniehotta, Presseau, and Araújo-Soares (2014) noted that although it was a dominant approach to guide health-related research for decades, many studies could not draw a robust conclusion about the usefulness of the framework and model. Some have criticized its focus on rational reasoning and limited predictive validity. Evidence has indicated that motivational measures, such as self-determination or anticipated regret, can predict behavior over TPB measures (Carraro & Gaudreau, 2013; Sniehotta et al., 2014). Experimental tests of TPB have been somewhat rare, yet from the application of TPB constructs researchers have been able to learn that interventions resulting in changes in intention are also likely to change behavior (Sniehotta et al., 2014). Experimental and comparative tests have been limited with this TPB as there has been more focus on the theory of reasoned action from which the TPB framework has been derived.

Although the current utility after three decades has been queried, the applicability of TPB to this research is the utility it provides in suggesting behavior is not always a simple reflection of attitudes, other explanatory measures can be considered including intention and subjective norm (Sniehotta et al., 2014; Wenhold & White, 2017). Exploring the perceptions of empathy and how it is then practiced will consider the applicability of the notion of behavioral intention; based on the possible premise that the best predictors of an actual behavior is the linked to intention of actually performing that behavior (Heuer & Kolvereid, 2014). TPB suggest that the more favorable attitudes

toward a specific act, the more favorable subjective norms, and the greater perceived behavioral control strengthen the intention to perform the behavior (Ajzen, 1991, 2005). TPB lends to be combined with a number of other frameworks, models, and theoretical underpinnings.

Grounded Theory

Grounded theory refers to a conceptual understanding situated in a particular context, it is meant to be reflexive (Ross & Watling, 2017). Grounded theory was first articulated as the constant comparative method (Glaser & Strauss, 1967) and gained prestige when it was used in published work concerning people dying in hospitals. Glaser and Strauss (1967) first discussed variations of grounded theory, and then Strauss and Corbin (1990, 1998) continued this discussion. While Glaser and Strauss (1967) operated within a positivist paradigm, Strauss and Corbin (1998) later evolved to adopt a constructivist approach, a similar view articulated by Charmaz (2006). Consistent with constructivist grounded theory principles stated by Charmaz (2006), Ross and Watling (2017) noted the approach to interviewing was the constant evolution of the theory as the researcher proceeded through data collection and analysis.

Corbin and Strauss (2008) stressed the importance of techniques, such as listening to the data for developing grounded theory. Constructivist grounded theory is inductive in nature and considers that, in human social science, there are multiple constructed realties that can be determined according to the view of the person experiencing the situation and the researcher theorizing (Charmaz, 2006). The roots of grounded theory posit that the theory is developed from the data from which it was derived (Gehrels, 2013).

Many scholars have used a blend and synthesis of theory to describe a new way of looking at social issues, such as family violence and spirituality (Graf et al., 2013; Singh & Hira, 2017). A limitation of this is the acknowledgement the researcher brings in their own perspective, especially if the researcher is an insider. Mills, Bonner, and Francis (2006) explained the grounded theory as a constructivist approach in reference to Charmaz's (2006) work. Mills et al. (2006) focused on making meaning from the data and representing experiences with theoretical interpretations. One could use grounded theory to emphasize the need to keep close to the data, honor the ability to keep these data intact, and maintain participant presence throughout (Charmaz, 2006; Mills et al., 2006). Grounded theory cannot aim for generalizable results, as it is influenced by context; however, transferable concepts and analysis can be applied to future research.

Summary

In Chapter 2, I reviewed the extensive literature related to defining empathy, significance of empathy, and the significance of empathy in clinical outcomes. I also presented literature that articulates empathy as a construct and teaching empathy as a construct. For the purposes of this study, I reviewed the literature on interprofessional competencies and practice in healthcare. In addition, I discussed interprofessional teams in healthcare and care teams of the future. The literature review also included a review of conceptual frameworks, including Barrett-Lennard's (1985) cyclical model of empathy and Ajzen's (1991) TPB. Finally, Chapter 2 included a discussion of grounded theory and its prevalence in research. In my extensive review of the literature, I did not find a model to explain empathy in an interprofessional setting. The next chapter describes how the

study fills a gap in identifying theoretical underpinnings and substantive theory development in the area of empathy practice and description. Chapter 3 discusses the methodology of this study and the data collection and analysis methods.

Chapter 3: Research Method

Introduction

The purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Additionally, I sought to understand how interprofessional teams conceptualized and operationalized empathy in their work with patients and families. In Chapter 3, I provide a rationale for selecting qualitative methodology to explore answers to the research questions in this study. I also discuss the basis for using a grounded theory approach in this study. Further, the roots of traditional grounded theory are described, along with the basis for utilizing grounded theory alignment. An examination of my role as a researcher, potential biases, and conflicts, as well as plans to manage these, are also included. Following these sections, I explain the population, sample strategy, data collection, data analysis, ethical considerations, and issues of trustworthiness.

A goal of this study was to discover a substantive theory to explain empathy in interprofessional healthcare teams. I uncovered elements to describe the conceptualization and operationalization of empathy in interprofessional teams. Although a number of theories described empathy as a construct, model, theory, or framework in individual providers, I did not find any explanatory theory in the literature that addressed my study's focus and research questions.

Research Questions

TPB concentrates on how an individual's intentional behaviors are based on belief, subjective norms, and perceived controls (Ajzen, 1991). This psychological model

asserts that these are the most important determinants of intentional behavior and function as a predictor of human behavior (Ajzen, 1991; Bracke & Corts, 2012). Because behaviors follow intention, TPB provided a theoretical framework to evaluate the impact of empathy attitudes, norms, and controls on the practice of empathy in a team setting. This provided a basis for this study and the following research questions:

RQ1: How do interprofessional teams conceptualize empathy in their work with patients and families in a healthcare setting?

RQ2: How do interprofessional teams operationalize their practice of empathy in their work with patients and families?

RQ3: What are the elements and theory that describe empathy in interprofessional teams?

Conceptual Framework

Using Ajzen's (1991) TPB as a social cognitive model to explore the cyclical phases of empathy (Barrett-Lennard, 1985), I explored the constructs within interprofessional teams in healthcare. The framework of this study was influenced by two structured approaches: (a) the constructs of empathy by Barrett-Lennard's (1985) phases of empathy and (b) the operationalization of empathy by the TPB framework. These approaches served as the foundation for developing grounded theory, which was contingent on consolidating perceptions of empathy along with operationalization of empathy within an interprofessional healthcare setting.

According to the literature, empathy can improve clinical outcomes, patient adherence, and patient-provider rapport (Kiosses et al., 2016). Empathy is a factor that

draws individuals to helping professions and can also play a critical role in understanding the experience of others; empathy involves cognitive, emotional, and behavioral capacities (Riess, 2017). To define the phenomenon of the conceptualization and operationalization of empathy in interprofessional healthcare teams, I conducted and analyzed the transcripts of semistructured, in-depth interviews with individual healthcare team members, as well as transcripts from focus groups with teams of varying disciplines.

Rationale for Qualitative Methodology

Qualitative research refers to methods of collecting and analyzing data that are different from quantitative methods that include statistical analysis (Kahlke, 2014). Approaches that are qualitative in nature are useful when exploring topics for which little is known, gaining insights, or making sense of themes to explain phenomena (Kahlke, 2014). I used a qualitative approach using grounded theory as outlined by Strauss and Corbin (1998) and Charmaz (2006) because the theory emerged from the data. My orientation was aligned with constructivist grounded theory (Charmaz, 2006), as it involved inductive exploration of a social process and the creation of an explanatory, descriptive theory based on the data collected. I assumed that the social phenomenon of interest was interpersonally constructed and dependent on the context that emerged from the interviews with members from varying disciplines.

I explored how interprofessional teams conceptualized and operationalized empathy in their work with patients and families. A qualitative approach was suitable for exploring the identified phenomenon because it was an iterative process to understand

this phenomenon through human experience, open-ended questions, and inductive analysis. Researchers using qualitative data collection could gather information from individuals about their experiences in real-life events and processes (Percy, Kostere, & Kostere, 2015).

The question of how empathy was described by interprofessional teams could be explored in the context of a quantitative study that utilized empathy measures, such as the BLRI or Reynolds's (2000) Empathy Scale (Barrett-Lennard, 2005); however, understanding the conceptualization of empathy was a goal of this study. In addition, other social research methods such as phenomenology could be employed to explore the subjective experiences of participants, or even field research to observe the natural state of teams. Although these methods would provide plentiful information about the participants, the purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Therefore, a qualitative study best fit this study.

Research Tradition: Constructivist Grounded Theory

I chose a qualitative study using a constructivist grounded theory approach to consider the notion of symbolic interactionism and understandings shaped by similar beliefs, values, and attitudes. Moreover, I determined how individuals behaved according to how they interpreted the world around them (Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Charmaz (2006) described discovering the theory in which the researcher used reflexivity and personal interpretation to arrive at theoretical

implications. This approach offered ways to employ critical qualitative inquiry, self-consciousness, and theoretical interpretation (Crossetti, Goes, & de Brum, 2016).

I aligned with Charmaz's (2006) evolved constructivist grounded theory inquiry because I used it not only to understand processes related to experiences but also to understand how participants interpreted and made meaning of these experiences in their lives (Maxwell, 2013; Singh & Hira, 2017). This method of qualitative research is used to develop a conceptual understanding of the phenomenon while honoring differences of opinion or perspective (Charmaz, 2006; Ross & Watling, 2017).

Similar to the traditions of positivism and the active role of people in its origins, constructivist grounded theorists assume that data or theories are not discovered but are constructed due to interactions with the field and participants (Charmaz, 2006). In this way, data are coconstructed, and the researcher is active in the interrogation of the data as these are analyzed. I used this methodology to have a critical lens with structure and rigor in this study.

In addition, I used grounded theory for future replication, advancing the research knowledge base, and an opportunity to study patterns (Charmaz, 2006). I acknowledged the structure of grounded theory as outlined by Glaser and Strauss (1967) but also emphasized that I as researcher could not be separate from the research (see Charmaz, 2006) in the evolution to constructivist grounded theory.

Central Concepts

The central concepts that I explored in my study included empathy, interprofessional practice, and IPE. The empathy construct, as described by Barrett-

Lennard's (1997) cyclical model of the phases of empathy, was a central concept in this study. The model included five steps: (a) Person A actively attends to Person B with an empathic set, (b) Person A resonates to Person B indirectly or directly in a way that becomes vivid for Person A, (c) Person A shows a quality of felt awareness of Person B's experiencing, (d) Person B is attending to form a sense of received empathy, and (e) the feedback and resonation continues to address confirmation or corrective content (Godfrey, 1981).

IPE was characterized by occasions when individuals from two or more professions in healthcare trained, learned, or cultivated collaborative practice for providing patient centered care (IPEC, 2016). IPE also occurred when individuals from two or more professions learned about, from, and with each other, as described by the WHO (2010) in Chapter 2. Interprofessional practice encompassed the practice where individuals with different professional backgrounds provided services by working together and with patients and families to improve care (Ketcherside et al., 2017).

Role as Researcher

My role as a researcher in this study was shaped by understanding that it was important not to oversimplify phenomena but rather to capture some of the complexity (Corbin & Strauss, 2008). Looking at data, no matter what the source, without a biased perspective was difficult, and my role as a researcher included understanding my own biases, accounting for these, and staying open in analysis about conceptualizations that might lead to core concepts and ultimately a theory (Charmaz, 2006; Corbin & Strauss, 2008).

This study was aligned to the notion that the researcher was not a passive recipient of the data; social science research was a world of varied perceptions, and acknowledging complexity was important in abstracting underlying theory (Corbin & Strauss, 2008). My ontological and epistemological position included being self-reflexive and recognizing the affiliation between theory, truth, and reality. An important concept was contextualism, whereby findings were constructed by intersubjective understandings of the phenomenon being explored (Charmaz, 2006; Strauss & Corbin, 1990); therefore, I stayed personally engaged with the research.

To mitigate bias, I conducted a wide range of interviews to get a rich picture. In Chapter 1, I discussed limitations and my worldview as a researcher. I had to ensure my previous relationships did not influence my interpretation of what participants shared (see Lub, 2015). The participant population was not selected from the hospital that I worked at previously. Instead, I asked other local hospitals and community healthcare settings for cooperation and research ethics board approval.

As a social worker, I was part of many interprofessional teams and used the skills of listening, observing, and communicating when I interacted with team members and patients. Influenced by Lub (2015), I intended to apply those skills to my role as a researcher and took a fresh view of what empathy meant, which required setting aside my own experiences to ensure the study was about the participants. I also ensured that I employed a method of member checking with participants to check for accuracy and resonance (see Birt, Walter, Scott, Cavers, & Campbell, 2016).

Methodology

Participant Selection

To select a sample of participants, I developed criteria discussed later in this chapter. I collected data using purposeful sampling, which was a common approach in qualitative research (Charlotte, Karin, & Johan, 2016). Purposeful sampling occurred when a certain sample was selected because I believed that interviewing a specific group could gather meaningful information, as based on research (Percy et al., 2015).

The goal of purposeful sampling was to gain rich data for the study; it occurred when a certain sample was selected because it was believed that rich data could be gathered from this group (Charlotte et al., 2016). A hospital setting demonstrated salient features relevant to this study, including clinical staff with potential knowledge about IPE, knowledge of individual roles, and ongoing support of interprofessional practice. Healthcare settings in the community, such as health clinics that provided interprofessional care, also emulated team-based care and practice.

For this process, I reached out via a formal letter to managers in a formal leadership role and responsible for the oversight of healthcare services in the hospital to request their cooperation in recruiting from their teams. I ensured availability to discuss any questions or concerns in person or by telephone. Purposeful sampling involved the targeted selection of interprofessional team members who were especially knowledgeable or experienced with working together to serve a common patient population (Palinkas et al., 2015). Study participants had to work in a healthcare setting functioning as part of a team made up varying disciplines, meaning interprofessional. I believed healthcare teams

would provide valuable insights on patient empathy due to their frequent and consistent work with patient populations. Participants were recruited as a team to participate in a focus group, as well as individual semistructured, in-depth interviews. I intended to have 9 to 12 participants in total, which meant 3 to 4 teams would participate in the study, which I thought would reach data saturation. However, there was a larger response than expected, which yielded more participants. Six focus groups were conducted with interprofessional hospital teams who agreed to participate together; following this, 24 individual interviews of the same participants were conducted.

For the purposes recruitment, I believed it important to define *team* clearly; therefore, I used Edmondson's (2014) work on *teaming to innovate*. Edmondson described teaming as a process of bringing together skills, as well as ideas from contrasting areas to produce something new. The concept of teaming denotes that no one individual can accomplish the task taken on by the team; in fact, this is crucial for innovation, as teaming results are more than the sum of the parts (Edmondson, 2014). In innovation, teamwork thrives when different disciplines and backgrounds come together to explore possibilities together. For participant recruitment, a team must consist of different disciplines intentionally working with the same population in a healthcare setting.

Edmondson (2014) used the example of a team working in a hospital emergency room and discussed how excellent communication was a prerequisite to high quality care. Effective teams are aware of roles and perspectives by using affective and cognitive skills. For this study, I recruited teams with varying roles and responsibilities, who self-

reported working toward common goals and outcomes in their patient care; meaning, team actions and service delivery must involve a purposeful practice and approach. IPEC (2016) noted interprofessional team-based care referred to one intentionally creating groups in healthcare who were recognized as having a collective identity or shared responsibility for a patient or group of patients.

Population

The population I sampled was healthcare professionals working in a hospital setting or healthcare setting in the community and in a team setting. The sample population for this study was comprised of a variety of backgrounds, and I targeted recruitment to a number of established and known teams in the hospital environment, including diabetes education teams, asthma education teams, obesity treatment programs, rehabilitation teams, mental health and addictions teams, intensive care teams, and palliative care teams. For the purposes of this study, it was not necessary for the entire team to be recruited; however, at least three participants from the same team were required for eligibility. Participants were not required to have previous training in IPE. I achieved depth by being consistently systematic in my approach to acquire rich information from participants. The sample population was recruited from inpatient and outpatient settings. Eligibility criteria for this study included the following:

- living in or near Toronto;
- age 18 years or older;

- healthcare discipline from any of the above named disciplines including; dietitian, social worker, physician, nutritionist, psychologist, nurse, nurse practitioner, psychiatrist, pharmacist, and physiotherapist;
- working in an acute care, community or rehabilitation hospital;
- working within an inpatient or outpatient team setting for at least 6 months;
- working with at least two other disciplines different from their own, delivering care to the same population;
- comfort in speaking English; and
- willingness to participate in a focus group with at least two other team members from their own team, as well as an in-depth, semistructured interview.

Recruitment Steps

To recruit participants for this study, I required a letter of cooperation from the hospital research ethics board. Following this, I sent out notifications to hospital managers via email. For healthcare clinics in the community, a research ethics board might not be required; however, a letter of cooperation was still signed. The notification letter asked for decision makers to forward the letter to their respective team members requesting their voluntary interest in participation. In addition to sending the letter to known managers of interprofessional teams, I followed up with identified managers for suggestions on additional potential participants. Once I had ample interest, I sent a letter of consent explaining my study and a request for their assistance in recruitment. Participants must understand they had to participate in a focus group and in-depth

interview to examine team and individual perspectives. Following the signed consents from participants, they first received proposed focus group participation times that matched their team members, as well as time slots for in-depth, semistructured interviews.

Instrumentation

I used a combination of focus groups and in-depth, semistructured interviews; therefore, I had to acknowledge that in qualitative research, I was the instrument (Kahlke, 2014). Separate interview guides for the focus group and interviews were developed (see Appendices B and C). The guides were grounded in the TPB framework and concepts of attitudes, subjective norms, and perceived behavioral control. To develop these guides with some rigor, I used Kallio, Pietilä, Johnson, and Kangasniemi (2016). They outlined a process for developing interview guides marked by five distinct phases, including (a) identifying prerequisites for using semi-structured interviews, (b) using previous knowledge, (c) formulating the preliminary guide, (d) pilot testing the guide, and (e) presenting the complete guide (Kallio et al., 2016).

I developed the interview guides using presupposition questions aligned with the research questions and built to obtain detailed insight from participants. The prepared questions assumed that respondents were experts in their lives, work, and experiences. In addition to Kallio et al.'s (2016) process for developing interview guides, I used multiple processes to add rigor. Kici and Westhoff (2004) provided guidance on developing behavior, feeling, values, and concept based questions that support research questions. A complementary process included developing probes to elicit additional information, as

informed by Charmaz and Belgrave's (2012) method to prompt deeper insights (see interview protocol in Appendices B and C).

I remained aware of the power differentials between an interviewer and participant, and I remained cognizant of this dynamic. As a researcher, I brought my own experiences, training, and history to this study, which could cause me to view and analyze the data in a particular way. I kept a reflective journal to examine and log personal reflections, consider assumptions, and engage in critical self-reflection. I also stayed aware that my training was beneficial, as I spent years learning to listen actively and probe with open-ended questions. I used these skills to augment my skills as an interviewer, as long as I remained aware of my ethical role.

Data Collection Techniques

Data collection was primarily collected in two ways: All participants first participated in a 60-minute focus group with members from their own team. Secondly, scheduled at a different time and date, each participant completed an in-depth, semistructured interview. I collected participant data in this way for a rich look at team and individual perceptions on the topic of empathy. The research phase began after receiving Walden University's IRB approval. I collected all data from in-person interviews.

The first phase included reaching out to surrounding area hospitals to request letters of cooperation and comply with organizational research ethics approvals as required. I also simultaneously contacted community healthcare clinics in the same manner. Following this process, the research personnel from the participating hospitals

and clinics were asked to forward a voluntary recruitment letter, along with letter of cooperation, via email and flyer to all formal managers in outpatient and inpatient areas. Instructions in the letter made the consent and voluntary participation explicit. Participants contacted me directly by phone or email to enroll. I conducted all interviews and prevented anyone from handling the data. I also requested space and room booking contact via the research personnel. Where possible, a room was booked on the hospital site. All interviews worked around patient care hours.

Interviews were audio recorded with permission acquired in advance; in addition, I took notes. The focus group guide was used to conduct the discussion. The in-depth, semistructured interviews followed the same approach; participants contacted me directly by phone or email. I scheduled a 60-minute, face-to-face interview when possible at the hospital site. A customized guide was utilized for the interview process. The guide served multiple purposes for my study. First, it offered a structure to the interview process to ensure all questions were pre-prepared. Secondly, the guide served as a collection tool for uniformity and comparability and helped minimize misinterpretation. For both the focus group and interviews, I used the guide to focus on listening, observing body language, and demonstrating attentiveness. I anticipated the data collection phase would last 1 to 3 months.

During the data collection phase, respondents called or emailed me directly from the information listed on the recruitment email or flyer. I provided information about the study and screened them as identified in the informed consent form. If they agreed to enroll through signing the consent form, I agreed to connect with them via email to first

schedule a focus group once all participants from their team were screened and enrolled. The voluntary enrollment of at least three members from varying disciplines was required before a focus group was scheduled. Therefore, participants who met eligibility criteria were asked to share the recruitment flyer or email with their team members if they had not already done so in advance of enrollment.

The informed consent form was reviewed at the in-person, data collection interviews, and a signature was requested before proceeding with the interview questions. At the end of each interview, participants were debriefed about the next steps, including member checking of themes emerging from their interview for validation via email. They were offered the opportunity to ask questions.

Data Analysis

All interviews were audio recorded and transcribed by myself. The collected data was coded using generic coding, where one considered codes, categories, and themes (Auerbach & Silverstein, 2003). Moreover, a grounded theory approach informed identification of relevant themes and keywords through an iterative process. In addition to building on Strauss and Corbin's (1998) grounded theory framework, the method of analysis that I incorporated was derived from Auerbach and Silverstein's (2003) strategies for coding and analysis, including the adoption of hypothesis-generating research.

Auerbach and Silverstein (2003) asserted that no one person was intuitive enough to read a series of transcriptions and see patterns immediately; therefore, I used the first cycle of coding to identify any slang, keywords, and relevant themes from the interviews.

The interview transcripts were reviewed thoroughly for valid examples in the text. Auerbach and Silverstein (2003) presented a 6-step process of coding as a rigorous method to reveal patterns. The six steps included three phases for constructing a theoretical narrative from text:

- Phase 1: making the text manageable. This phase included Step 1, which involved explicitly stating research concerns and theoretical framework, and Step 2, which focused on reading raw text to select relevant portions for analysis
- Phase 2: hearing what was said. This phase included Step 3, which denoted the need to record repeating ideas by grouping related passages together, and Step 4, which focused on organizing themes by grouping repeating ideas into categories
- Phase 3: developing theory. This phase included Step 5, which relayed the process of developing theoretical constructs by grouping themes into abstract concepts consistent with the stated theoretical framework. Finally, Step 6 was articulated as creating a theoretical narrative by retelling participant stories via the theoretical constructs (Auerbach & Silverstein, 2003).

Issues of Trustworthiness

Qualitative research and inquiry can answer open-ended questions through inductive analysis by still seeking to provide rigor, credibility, and reliability (Watts, 2014). Because qualitative researchers serve as a measure of validity, triangulation will aid in establishing trustworthiness and credibility. This study included data collection

methods of focus groups and in-depth, semistructured interviews. It was difficult to address the issue of confirmability due to potential biases, such as researcher personal motivations. I took steps to ensure the findings were a direct result of participants in the study, including conducting interviews with objectivity, reflexivity, and saturation. I kept a journal and log of thoughts, which was reflective.

When reliability is addressed in qualitative research, then credibility is represented by internal validity and the congruence of findings (Lub, 2015). I used triangulation, debriefing, member checking, and saturation to establish credibility. Member checking occurred once interviews were transcribed; each participant received the arising themes from their transcripts via email and the opportunity to clarify, omit, or add to their responses via email. In this way, I directly established trust and rapport.

The grounded theory method provided trustworthiness because the theory came from the data originating from participant responses (Charmaz, 2006; Glaser & Strauss, 1967). In terms of transferability, this study occurred in a particular context, and individuals could decide how study findings related to their experiences. Conducting this qualitative research study could show opportunities for findings to be applicable to other similar contexts and situations, such as nonhospital settings or healthcare delivery teams of other disciplines not included this study.

Ethical Considerations

In qualitative research, researchers must consider ethical implications of the study. Ethical considerations for this study included how I contacted, recruited, collected, and protected the data. The interview notebooks and information were marked using a

unique identifier coding to conceal identities. Each participant was debriefed on the interview process, data collection process, measures to ensure confidentiality, and voluntary participation. The participant data are treated confidentially, stored on a hard drive in clearly marked separate files, and be destroyed after 7 years.

An additional ethical consideration involved taking steps to ensure informed consent. Participant recruitment did not begin until approvals from Walden University's Institutional Review Board (IRB) are received. The first step in advance of data collection included explaining the study through the informed consent process, as required by the Walden University IRB Consent Form. Potential benefits and any foreseeable risks were explained clearly, and I acknowledged receipt of approval to administer my study.

Summary

In Chapter 3, I discussed the research methods, sampling, data collection, and analysis methodology. In summary, the sample consisted of six focus groups and 24 individual interviews. I first conducted focus groups with intact teams, followed by in-depth interviews with each participant. Using a grounded theory approach, the data were collected, analyzed, and coded. I also discussed my role as a researcher, conflict, and bias, as well as ethical considerations.

Chapter 4: Results

Introduction

The purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Specifically, I showed how the conceptualization and operationalization of empathy in interprofessional teams translated to clinical practice. The constructs of empathy were important to this research and influenced this work. Barrett-Lennard's (1985) cyclical model of the phases of empathy framed the study; in addition, this research was informed by the constructs in the TPB framework to acknowledge the relationship between conceptualization and practice. Moreover, grounded theory method was used for analysis; by using this approach, a midlevel theory was extrapolated from the data collection and subsequent analysis (Charmaz, 2006; Glaser & Strauss, 1967). A midlevel theory falls between the sphere of everyday research and social systems theories (Crothers, 2004).

This chapter provides a synopsis of results from the data collection focus groups and individual interviews that ultimately led to the development of a midlevel theory. In this chapter, I describe participant recruitment, data collection, and data analysis. I discuss the research setting, ethical considerations, participant demographics, evidence of trustworthiness, and data analysis techniques in this chapter. In addition, I present overall findings of conceptualization and operationalization of empathy as well as theory generation. Finally, I discuss results, evidence of trustworthiness, credibility, transferability, dependability, and confirmability.

Research Setting

The research for this Canadian study was conducted in an urban center in the province of Ontario in Canada. Participants responded to my research letters of invitation sent by the administration of the site to all managers and directors to share with their staff. When participants responded, we mutually agreed on a time for a 10-minute telephone discussion, where I screened for eligibility using the Demographic Screening Questionnaire (Appendix A); for those who met the criteria, a follow-up e-mail with the consent form was sent. Prior to all interviews, consent forms were returned by e-mail or by paper copy.

All interviews were conducted in person at the healthcare work site of all participants during the working day, lunch hour, or prior to the work day. Focus groups occurred in a private meeting room booked with the support of the participants; similarly, individual interviews occurred in a private office setting at the work site. Participant interviews were booked and confirmed by e-mail, and a reminder message was sent for focus groups and individual interviews in advance. I maintained a tracking sheet, recording participant initials, contact information, and assigned code numbers.

Ethical Considerations

I followed the elements of the ethical protocol outlined in Chapters 2 and 3. The Walden University IRB approved the research protocol for this study, as well as the informed consent form (IRB Approval No. 07-24-18-0661597) before data collection started. In addition, I sought Research Ethics Board approval from the healthcare site and

obtained endorsement and approval prior to any recruitment e-mails or data collection procedures. The research study was vetted through the senior administration at the site.

The informed consent was sent to all participants via e-mail, and they had an opportunity to subsequently ask questions. Prior to the interview, I confirmed the consent form was signed and advised of the duration and expectations of the interview, including audio recording. Because the first part of the study required a focus group participation, participants were also advised of follow-up activities including booking an individual interview time by e-mail and member checking process. All documentation concerning participants and any cross-referenced materials, such as the Demographic Screening Questionnaire, were assigned unique numeric codes. All interview data were stored in a locked cabinet; transcriptions and audio files were stored on password-protected computerized file.

Demographics and Data Collection

This section provides a summary of the research participants in the study. Six focus groups were conducted with interprofessional hospital teams who agreed to participate together; following this, 24 individual interviews of the same participants were conducted. All participants enrolled in the study participated in both a focus group and an individual interview. Each focus group was 45 to 60 minutes in length, audio recorded, and subsequently transcribed verbatim. The individual interviews followed the focus groups and were booked via e-mail with each participant for 30 to 60 minutes, audio recorded, and transcribed verbatim. The Focus Group Questions Guide and Individual Semistructured Interview Guide were utilized (Appendices B and C). Table 1

provides an overview of demographic information of all participants. Each participant partook in a focus group first, followed by an individual face-to-face interview.

Table 1

Participant Demographic Information

Participant	Gender	Discipline	Patient population served
1	F	Social worker	Diabetes
2	F	Dietitian	Diabetes
3	F	Nurse practitioner	Diabetes
4	F	Dietitian	Diabetes
5	F	Occupational therapist	Geriatric
6	F	Registered nurse	Orthopedic
7	F	Recreation therapist	Rehabilitation
8	F	Occupational therapist	Geriatric
9	F	Social worker	Geriatric
10	F	Dietitian	Rehabilitation
11	F	Registered nurse	Geriatric
12	F	Speech language pathologist	Rehabilitation
13	F	Social worker	Diabetes
14	F	Occupational therapist	Rehabilitation
15	F	Social worker	Rehabilitation
16	F	Registered nurse	Rehabilitation
17	F	Physiotherapist	Geriatric
18	F	Dietitian	Geriatric
19	F	Registered N\nurse	Diabetes
20	F	Registered nurse	Geriatric
21	F	Registered nurse	Orthopedic
22	M	Registered nurse	Orthopedic
23	F	Occupational therapist	Orthopedic
24	F	Physiotherapist	Orthopedic

Data Analysis Techniques

Congruent with grounded theory methodology, I remained open to all possible theoretical underpinnings. I dedicated coding to developing a relationship with the data to engage in coding a large number of transcripts. Therefore, I specifically sought to discover peoples' experiences. I used a process of line-by-line coding to identify and define actions and meanings and to crystalize the significance of points made (Charmaz, 2006). Glaser and Strauss (1967) stated that at this stage, researchers could ask, "What is

this data a study of?" and "What does the data suggest?" (p. 20). I utilized this method of inquiry to create simple and precise codes.

Auerbach and Silverstein (2003) outlined a step-by-step procedure for grounded theory generation in qualitative research, and I followed their methodology in this study. In this study, I followed the distinct phases of the coding process as outlined in Chapter 3. In the first phase of making the text manageable, I increased awareness by reviewing the transcripts in the context of the stated research questions and the conceptual approaches that framed this study. -Auerbach and Silverstein (2003) described the first process of reading transcripts and identifying segments as marking *relevant text*. For example, relevant text would include any reference to empathy feelings, behaviors, or thoughts. After this process, I moved to identifying segments that expressed similar ideas, known as *repeating ideas* (Auerbach & Silverstein, 2003). This second phase was denoted by hearing what was said, grouping passages, and beginning to organize themes by grouping, and even regrouping repeating ideas.

Finally, repeating ideas were grouped in more abstract level themes, repeating ideas became clusters of relevant text, and themes emerged from clusters of repeating ideas (Auerbach & Silverstein, 2003). This third phase was the developing theory phase, which included developing constructs and looking for consistency with the stated theoretical framework. I formulated a narrative via participant stories in a theoretical narrative. A summary example of coding, relevant text, and themes is provided in Appendices D and E.

Constant comparison of data was also grounded by memos that I hand wrote or typed due to emergent ideas for theory generation. This process prompted me to analyze codes early in the process in a habitual manner (Charmaz, 2006). I used memos and qualitative codes to inquire about connections my participants shared, action statements, and meaning.

Focus Groups and Individual Interviews

I collected data via focus groups and individual interviews to explore elements of conceptualization and operationalization in a verifiable technique that was both trustworthy and credible. I used this process to address multiple strategies for ensuring triangulation and data capture. Charmaz (2006) defined qualitative method triangulation as a strategy that provides a more comprehensive approach. By integrating focus group and individual interview data, I used a productive iterative process. The exploration was guided by an initial identification of contextual circumstances, which later enriched successive individual data interviews. This process added to interpreting the constructs and emerging themes. The combination of strategies contributed to synthesis and knowledge production.

Results

The experience of interviewing 24 different clinicians about their views on empathy was a new journey into the privacy of their practices. Most clinicians shared they had not been asked to stop, pause, and think about their understandings and practices of empathy. They often remarked on the complexity of the concept of empathy, and this study allowed deep inward analysis of something that felt ordinary and natural yet had

such intricacy. As participants began to contemplate on what the questions meant to them, many emotions, experiences, reflections, and thoughts emerged, and I was honored to bear witness to them. To provide evidence for the themes generated in this study, I used participant quotes to represent participant reflections, examples, and voices.

As an overview, six focus groups and 24 individual verbatim transcripts, totaling 30 transcripts of over 1,500 pages, were analyzed for statements and arranged into meaningful categories, resulting in a midlevel theory characterized by four themes: (a) empathy as team is valuable, (b) empathy is not accidental, (c) empathy among interprofessional team members is a prerequisite to clinical empathy with patients and families, and (d) genuine intent is vital to the empathy relationship.

Unusual Circumstances and Variations

The study included a variety of disciplines, such as social worker, physiotherapist, recreation therapist, nurse, nurse practitioner, speech language pathologist, dietitian, and occupational therapist. This study yielded a number of common responses among healthcare workers from the same discipline; similarly, there were also responses specific to a participant's expertise and training. In reporting the results of this study, I did not link participant quotes with specific disciplines to preserve confidentiality. In addition, the healthcare community in this city is well connected and there are several community and hospital partnerships across the city.

As noted in Chapter 3, my intention was to recruit from urban area hospitals and healthcare settings to arrive at the recruitment pool of 9 to 12 participants, inclusive of 3 to 4 teams. However, the response to recruitment was greater than anticipated, with

interest from more than eight teams and 30 participants from the first recruitment site. Therefore, I sought approval from Walden University's IRB to instead increase the pool to 17 to 25 participants and 4 to 7 teams. The study proceeded with one site, where teams who reached out were screened and recruited on a first come basis.

Conceptualization of Empathy

The first part of this section answers the first research question:

RQ1: How do interprofessional teams conceptualize empathy in their work with patients and families in a healthcare setting?

This question addressed the descriptors and reflections affiliated with empathy as characterized by (a) symbolic attributes, (b) deep personal experiences creating meaning, and (c) purposeful perspective taking.

Symbolic attributes. Participants noted empathy had many facets, with varying definitions in a healthcare setting. Several participants described empathy as "walking in another person's shoes" or "trying to understand feelings" and reflecting their understanding back to patients. One participant characterized a key attribute of empathy as "borrowing an individual's experiences, their feelings and their situations to support them." Others talked about empathy as being made up of validation, caring, compassion, and respect. For some, empathy was a platform to enable the ability to "treat them with humanity" or to convey warmth.

The element of symbolic attributes was affirmed both in team focus groups, and further synthesized in individual interviews. Focus group data yielded the importance of team members not only understanding one another's frames of reference but also having

agreement on many attributes amongst one another. In individual discussions, a repeated concept was the ability to acknowledge a team member's descriptors of empathy but also to find value in the viewpoints of another professional to possibly adopt a set of attributes related to empathy. Common attributes included validation, compassion, and a mindful union of body, language, and words.

Notably, symbolic attributes did not have large variance among the different disciplines. On several instances, participants commented that there were common threads that drew them all to healthcare, regardless of their training and expertise. There was large agreement that empathy attributes could be experienced and demonstrated by all members of the team at varying points in a person's care.

Deep personal experiences create meaning. Empathy is a deeply personal experience. The large majority of participants conveyed their first memories of learning about or experiencing empathy was as children and at home. Examples of these experiences included doing volunteer work, canvassing for charitable causes, and being taught by caregivers of empathy as a desirable quality. Several focus group participants relayed the importance of deep connections through statements such as "it was how I grew up" and "how empathy was named in your family," and noting "unless you seek out the knowledge, then you can't really practice empathy." Participants shared personal experiences in far larger depth during individual interviews. They remarked on how important it was to learn from "experiencing loss" or personal memories such as "taking care of my grandfather." Participants individually remarked on the influences of role models stating, "I think it's the role models you have in your life as your parents or your

grandparents or the family." For several participants, empathy was fostered over time at home, through clinical practice; interestingly, many noted "being drawn to healthcare" as a natural outcome of having the asset of a good empathic nature.

While this element in particular was infrequently explored in great depth during focus group settings, team members acknowledged their learning extended far beyond didactic episodes. At times, during focus group interviews, members remarked generally on experiences that might contribute to creating meaning, such as facing loss, dealing with grief, or having children. The largest exploration of this element came from multi-layered exploration during individual interviews of deep experiences. The individual interviews largely conceded empathic appreciation was solidified by personal experiences. The variety of individual experiences was communicated as accepted; the important factor was the ability to reflect on these individually and collectively. I did not conceive of any significant findings related to empathy experiences, as experienced by distinct professions.

Purposeful perspective taking. The importance of empathy was conveyed as having "to understand where a person comes from" to counsel on changes and healthcare. Empathy was also seen as "part and parcel of the patient journey" and key to "legitimizing their feelings and concerns." Rapport and trust were often affiliated with empathy as an important enabler for delivering care. This finding was especially true when caring for patients struggling with a new diagnosis; a change in health status; or experiencing an unexpected health event, such as stroke, surgery, or onset of diabetes. Empathy was also important in communicating with caregivers and families. The

significance of listening, engaging, and kindness was conveyed as essential for partnering with families: “They are grieving the loss too; it’s their family.” Participants noted they purposefully tried to understand and take the perspective of their patients by trying to “walk in their shoes” or “emotionally understand where they were coming from.” Perspective taking was described as a decided act to imagine their patients’ world and join in their journeys on an emotional and cognitive level.

The element of purposeful perspective taking commonly presented in focus groups and individual interviews. During team focus groups, a common concept was the ability to walk in another person’s shoes; in fact, a variation of this concept was evident in all focus groups. A further synthesis of this theme emerged during individual interviews, where several participants remarked on this being foundational to building rapport and resonating understanding. Of significance, social work participants noted the concept of perspective taking was learned in their education through simulated patient experiences. Other professions, such as dietitians, remarked on inpatient rotations as a mechanism for increasing perspective taking. Additionally, in some instances, physiotherapists and occupational therapists recalled the linkages between deep personal experiences around empathy and perspective taking, especially when providing physical therapy. A summary of conceptualization of empathy is provided in Table 2.

Table 2

Conceptualization of Empathy

Characterization	Participant voices samples
Symbolic attributes	"meet people's needs" "how will I make things better?" "let's see a person's point of view" "neurological mimicking" "Lots of looking, smiling or frowning" "being sensitive even to somebody's body language or energy" "validating and supporting" "being a very good listener, having those listening skills and knowing that it's inappropriate to tell the patient about your own personal stuff" "Listen, then you have to make them realize they're being heard" "understanding is really important" "compassion" "treat them with humanity" "attention to the strength they are good at" "It also means not always being solution oriented, like sometimes your job is really just to, to feel with the patient and validate" "patience and understanding and being gentle" "nonverbal and how you present yourself" "the nodding, the smile of the eyes, you know just validating their experiences" "supportive conversation" "warmth" "It's just listening and understanding what the patient is going through and validating that" "you have to believe what a person's telling you"
Deep personal experiences create meaning	"I have to say this, that being a role model, not only for our colleagues, but it's also for patients that via empathetic intention patients will have empathy for themselves" "treating others how you want your connection" "we're borrowing an individual's experiences their feelings and their situations, but simultaneously keeping a safe distance and detachment to knowing that that's not our life" "…I do a little meditation… So then when I go out, I'm really connecting right away. No judgements" "My mother intentionally teaching me empathy" "volunteering, canvassing" "…ultimately, I would say it was my mother" "taking that other person's perspective of what you can do for them to make a difference in their life" "how I grew up" "seeing poverty" "telling patients you can still have a meaningful life and you could still have purpose and you can still be happy…" "taking care of my grandfather" "experiencing loss"

(continued)

Characterization	Participant voices samples
Deep personal experiences create meaning	"for me it improves my own satisfaction because I think when I'm able to empathize with the patient and I can see that they feel heard, that they feel validated, that they just feel listened to, I feel like they're getting more from the interaction" "I think certainly my own experience in the healthcare system, my own family, like when my grandfather was sick" "how your parents interact with you and how they name your emotions" "being a parent taught me the importance of empathy" "I think it's being raised in a family where empathy is valued" "my father for example was very involved in the community…" "I think it's the role models you have in your life as your parents or your grandparents or the family" "it comes back to you like a boomerang" "it starts early but I think it definitely grows and evolves as you do" "Unless you seek out the knowledge, then you can't really practice empathy" "you're probably drawn toward a certain profession just based on some sort of innate characteristics that you have" "I think you have to understand your own set of values and also personal maturity"
Purposeful perspective taking	"you can imagine yourself in their world or what it would be like you can relate to" "just being in the person's shoes, being that person , just tapping into how would you feel if you're in that situation" "trying to relate to them and trying to make them understand that if you don't know exactly what they're going through, that you want to engage with their feelings, make them feel heard" "You're able to, as a clinician, borrow their feelings for a moment and borrowing their experiences whether you have lived through that or not, and still keep those healthy boundaries and be able to not bring that to your own life" "understanding emotionally where they're coming from" "walking in their shoes" "just being in their shoes"

Operationalization of Empathy

This next part of this section will address the second research question: How do interprofessional teams operationalize their practice of empathy in their work with patients and families? This question addressed the actions and intent affiliated with empathy, as characterized by (a) team behaviors influence clinical outcomes, (b) empathy as a collaborative engagement, and (c) empathic intent.

Team behaviors influence clinical outcomes. Empathy and its relationship to clinical care was first explored during focus groups, and further discussed in individual interviews. The notion of empathy as a mechanism for increasing patient adherence to

treatment, elevating motivation levels, and enhancing patient satisfaction was supported with statements, such as “the connection will lead care,” “as much as its patients I am dealing with, it’s also the whole system,” and “it matters what the team thinks and that’s because there is a genuine partnership in place.” When asked about how empathy might influence clinical outcomes, some participants noted the role of empathy when hospital indicators were measured on a daily basis:

> I think it actually helps us get to the outcomes that we want and in a way that hopefully is more efficient and is better for the patient and the organization because you're hopefully engaging patients better and then make good transitions, hopefully it translates into better outcomes.

The large majority of participants relayed improving clinical outcomes was a team responsibility; to facilitate this, they engaged in purposeful activities. Examples included team huddles to share medical and nonmedical aspects of patient assessments, case conferences, and joint care planning through shared documentation. One team shared that rating confidence and conviction regarding patient perceptions of change helped them develop empathy by learning about the patient vantage point: “Sometimes, you're the bridge between something so simple as basic needs like food and other times you're the voice for a discharge plan or a destination or a clinical outcome.” Teams noted that addressing clinical outcomes included mindful tactics, such as being aware of unbiased language, avoiding medical jargon, and creating a physically inviting environment.

This particular element presented both in focus groups and individual interviews with significant repetition. The concept of interprofessional practice emerged as an enabler for care. Teams acknowledged interprofessional practice as not only important in their work but also important as a mechanism to bring together varying expertise. There was large agreement among team focus group participants that bringing together disciplines to work together consistently as a team strengthened and enhanced care. This concept was further solidified in individual interviews, as participants relayed their preferences of working in a team versus individually. No one specific discipline noted a preference for specific disciplines to be on the team, but rather the necessity for the group to be diverse in their expertise. Significantly, distinct behaviors, including team meetings, joint care planning, and deliberate team building support, were overwhelmingly endorsed. Teams linked team behaviors to building rapport with not only patients but each other, as well.

Empathy as a collaborative engagement. Often participants linked empathy to patient-centered care. In fact, statements that endorsed empathy as a necessary ingredient for team-based care included “if you aren’t able to form a connection with the patient, the patient doesn’t always want to engage in your therapy,” and “it helps with a more holistic plan.” As participants reflected on empathy as a team practice, several remarked on how it became part of their normative behavior; others commented on connectivity: “If you're interwoven enough, you start to know each other's strengths,” and “we all have our roles, but a lot of what we do can kind of overlap, and we have that connection with each other and the ability to know what another professional can do for a client and that's

important." Empathy was seen as an interactive process and complex to explain but not do; for example, "it's just so embedded in everything we do" and "it should just be a team effort."

An interesting and relevant emerging concept was that of interprofessional empathy amongst team members. Teams and individuals mentioned the desire for patients to see them as a cohesive team that "gets along well together," and "seeing the differences as an opportunity to bridge that gap and create insight and awareness." In fact, several participants shared their own empathic practice had grown from being supported by their colleagues through various life stages and acknowledging an open environment. Sharing workload, staying vulnerable, and being open to dialogue were aspects of demonstrating empathy to one another "in the absence of empathy for each other, patient care can also be compromised."

The element of empathy as a collaborative engagement was supported by several factors. Firstly, teams demonstrated collaboration by how they engaged with one another during focus groups. They praised each other for their work and provided examples of one another's demonstration of empathy in practice. Secondly, in Chapter 3, I noted Edmondson's (2014) concept of teaming as a process of bringing together skills and ideas from contrasting areas to produce something new. During focus groups, teams acknowledged no one member could deliver the care in isolation, and they sought innovative ways to stay connected and cognizant of patient issues. Lastly, teams were respectful of differing views of empathy, sought opportunity to build on each other's

comments, and acknowledged when they learned something new from other participants by way of validation and positive body language.

Collaborative engagement was further endorsed during individual conversations. Some participants remarked on sharing deep personal experiences with members of the team as a mode of rapport and support. Individual interviews positively endorsed the concept of team cohesiveness as important in job and patient satisfaction.

Empathic intent. Intention was explored as a concept of action and desire. Participants had not often thought of empathy and intention in the same conversation; however, when probed, they noted the relationship with comments, such as having the intention of positivity toward patients and "listening for hearing." The intentional aspects of talking about their joint patients' strengths and abilities were seen as upholding an empathic and honorable approach. The same was noted when there were concerns about health risks or outcomes; participants noted they worked together to problem solve, while being mindful of judgment and bias.

Empathic intent also included the ability to be reflective, such as "adjusting your own agenda" and "offering something that might be relevant to them." Within this self-reflection, some described learning to go with a genuine interaction, as it often illuminated meaningful details about their patients. Intention was described specific to how patient care was delivered using simplified approaches to relay new information, recognizing cultural diversity, and reading body language. Body language was characterized by communicating at eye level by moving a chair closer or sitting at the edge of the bed, smiling, nodding, and matching breathing or tone. Intentional desire was

seen as something innate, which one either had or did not have. Additionally, the intent to be empathic could be seen as a choice "if you aren't an empathic person, you don't care enough to look deeper," and "it can be learned over the years of practice. It can be cultivated, and role modeled, but one does need to have the right intent," and "I have my own standards. I only expect excellence." Finally, it was conscious because "you have to be mindful of what you are doing."

One must note the relationship some participants shared between intention and mindful practice. One participant noted that after meeting a new client, she acknowledged,

You don't know what this person is all about… you don't know what this person has been through… and so I do a quick meditation before I see the patient and it really helps, so when I see the patient, I'm really listening without judgement.

Another participant shared a profoundly meaningful way she engaged in being empathic: "I picture everybody as a little baby and just kind of knowing that everybody is someone's child."

The element of empathic intent first emerged in several focus groups and was further explored in depth in individual interviews. There were no significant differences in how this element was described by profession, but rather an endorsement that disciplines required specific intent to work in healthcare. Intent as a team practice was linked in two ways: intentional case conferencing or care planning and deliberate communication. Empathic intent as a team was measured by using appropriate language when speaking about patients, considering the role of culture, and intentional

involvement of families or caregivers. There was also general agreement that team display of empathic intent required the inclusion of several of the above noted acts not just one. Flexibility and adaptability were seen as enablers.

During individual interviews, the connection between intent and action was further revealed. Bridging from an intentional desire to be empathic to an intentional positive act included several facets: awareness, mindfulness about personal and lived experiences, and personal standards of care. Cultivation of empathy was seen as valuable, as long as the prerequisite of intent served as a foundation. In this context, empathy could be taught as a skill if intent as a prerequisite was operationalized by understanding three areas: personal values, ability to be reflective, and empathy as a motivator for better service delivery. Evidence for operationalization of empathy is provided in Table 3.

Table 3

Operationalization of Empathy

Characterization	Participant voice samples
Team behaviors influence clinical outcomes	"I think the case conferences or that's a great way as well as, the interdisciplinary care plan that we were talking about it because that's a care plan that we're all required to complete"
	"You know, at the end of the day it actually helps you get to your goals and ultimately to truly patient centered as well"
	"If we can be empathetic, then we can, create a future plan, know how to obtain those supports for that patients"
	"Coaching and building a common language"
	"huddle in same space"
	"talk to each other day to day"
	"daily rounds"
	"team building"
	"leadership is included in this"

(continued)

Characterization	Participant voice samples
Empathy as a collaborative engagement	“case conferences” “team communication” “regardless of how different our views are, we are respectful of each other and where we all come from” “I guess I think I have to think that our patients sometimes teach us, and I'd like to think that working in a team that your team members also teach you and you kind of learn from each other” “trust one another and open conversations” “Understanding what a family or a patient brings and starting with them there and of perhaps some of the challenges or the barriers that they may come with as well as certainly their strengths” “rapport building” “validating those feelings that the patient is expressing so that you're able to find a common ground with that patient because that really truly directs all your care” “This is that the human connection is so important and if patients feel that they can trust their team that the team is hearing them” “tapping into what it is that they are that's most important to them” “to adopt their perspective to find ways that you can support them. especially for us to support them to achieving their goals” “a big part of my job is focusing on their strengths” “patience” “trust” “I believe that there is even empathy amongst our team members”
Empathy as a collaborative engagement	“taking the empathy and not only trying to be able to show toward our patients…but also to one another” “it’s a team sport, it’s definitely not associated with one person” “having empathy for each other” “empathizing with each other’s roles” “understand each other” “appreciate each other’s strengths” “if you're interwoven enough, you start to know each other's strengths” “addressing compassion fatigue or burnout” “we have that connection with each other and the ability to know sort of what another professional can do for a client and that's important” “mutual respect” “I think people have to feel like their team is empathetic toward each other. I think its part of being a cohesive team. When people feel respected and heard that then translates to the care that they give when people feel valued”
Empathic intent	“I still sometimes when parents tear up, I find myself doing that sometimes too and I find I do that more now than I did before, but being authentic” “you actually actively want to be empathetic, you choose to be empathetic” “show them I understand” “not only understanding what they're presenting or telling, but also looking beyond that” “It's the ability to have engaged detachment” “it's not even about what you say, sometimes it's not saying anything at all” “I do think going in with the intention, first of all, to understand what their experience is incredibly important”

Comparison of Focus Group and Individual Interview Data

As a construct of conceptualization and operationalization, empathy was explored, observed, and validated in team-based focus groups, and then during in depth semi structured interviews. Although the data yielded some differing perspectives on the conceptualization and operationalization of empathy, the resulting data were complimentary. A general comparison is provided in Table 4.

Table 4

Comparison of Focus Group and Individual Interviews

	Individual	Focus group
Symbolic attributes	Respect	Validation
	Humanity	Compassion
	Validation	Body Language
	Compassion	
	Smiling	
	Nodding	
Deep personal experiences create meaning	Childhood	Emotional experiences
	Family	Caregiving
	Hardship	Appreciation
	Caregiving	
	Meaning	
Purposeful perspective taking	Rapport	Patient centered
	Trust	Rapport
	Patient journey	Trust
	Personal experiences	Kindness
	Walking in shoes	Understanding
	Joining	
Team behaviors influence clinical outcomes	Connectivity	Whole system
	Holistic care	Engagement
	Patient care	Job satisfaction
	Self-fulfillment	Communication
	Responsibility	Joint planning
	Empathy for each other	Care for each other
Empathy as a collaborative engagement	Together	Cohesiveness
	Collective practice	Interprofessional
	Interactive	Enhanced care
	Get along	Requires support
	Builds over time	Strength in numbers
	Valuable as a team	Collective growth
Empathic intent	Personal values	Morals
	Reflection	Personal Standards
	Engagement	Innate
	Motivation	Life experiences
	Innate	Foundations
	Nurtured	Learned by exposure
	Experiential	Deliberate
	Cultivation	Reflective practice
	Mindfulness	
	Awareness	
	Standards of care	

Overarching Constructs and Theory Generation

The final part of this section will address the third research question: What are the elements and theory that describe empathy in interprofessional teams? This question addressed the key thematic elements related to bringing conceptualization and operationalization of empathy into team practice and the space in which they existed together. Many of the findings were congruent with the guiding theoretical constructs, as outlined by Barrett-Lennard's (1985) cyclical model of the phases of empathy and Ajzen's (1991) TPB.

Barrett-Lennard (1997) noted that although the empathy cycle was not closed, empathy could begin with actively using an *empathic set,* including a desire to know. The findings of this study included participants validating, supporting, and actively listening to patients. In this way body, language, tone, and interpreting the patients' needs was crucial, and participants in this research articulated the same importance. Moreover, Barrett-Lennard (1997) noted these as preconditions. Empathic resonance and expressed empathy were consistently expressed by participants by using validating language and recognizing not only patient goals but feelings, as well. This process could be automatic or intentional, and Barrett-Lennard (1997) deemed this process as necessary for one receiving empathy. While participants did comment on noticing when patients felt or saw their empathy, they characterized this most often by recognizably relaxing, smiling, or nodding and expressing a feeling of "connectivity."

In addition, a number of concepts specific to intent and attitude toward a particular behavior did emerge. Ajzen (1991) suggested a framework to explain that

attitude toward a particular behavior, subjective norms, and perceived control shape intention. Participants noted they had favorable feelings toward empathy as part of their healthcare provision. This aspect was also characterized by their understandings that the literature and healthcare culture endorsed caring, compassion, and kindness as important. Participants endorsed empathic behaviors could be role modeled, and others would see this as valuable.

Depending on the situation, empathy and control over its demonstration could be varied by factors, such as time, energy, and burnout. Ajzen (1991) considered a person's perception of the ease or difficulty in performing a behavior; participants in this study characterized empathy as sometimes being natural, and other times, requiring specific attention, intention, and exertion of time. Ajzen (1991) noted the difficulty in measuring or accounting for factors, such as mood or past experienced. However, participants in this research study often endorsed the linkages between past empathy learning experiences, how this shaped attitudes, and how it influenced subjective norms.

I explored for the elements in which empathy and its relationship to interprofessional teams could be explained. To this end, the space in which empathy exists in this work was characterized by the interpersonal elements of how it was interpreted, valued, and demonstrated. The prerequisites for empathy centered care and its relationship to clinical outcomes were also uncovered in the findings of this study; these were seen as ingredients for the provision of team-based care in a healthcare setting. This research study's overarching findings about the conceptualization and operationalization of empathy presented a number of elements outlined earlier in this

chapter; these elements were contained within four main constructs that functioned in parallel:

1. Empathy as a team is valuable: Symbolic attributes
2. Empathy is not accidental: Deep personal experiences create meaning, and purposeful perspective taking
3. Empathy among interprofessional team members is a prerequisite to clinical empathy with patients: Team behaviors influence clinical outcomes, and empathy as a collaborative engagement
4. Genuine intent is vital to the empathy relationship: Empathic intent

Empathy as a team is valuable. Teams in healthcare served complex patient populations and addressed medical, psychosocial, and social issues. Significant emphasis was placed on building teams who were interprofessional in nature, skilled, and flexible. To value empathy and the practice of empathy in a team setting, a collective acknowledgement and agreement of its key attributes was necessary. While there was variability of how empathy was defined, attributes that acknowledged the value of empathy must be endorsed by the team; then, empathy as clinical competency was seen as valuable.

Empathy is not accidental. There were a number of innate features of empathy; however, the way in which empathy was fostered was through life experiences. Providers drew on their experiences to take the perspectives of patients and families they work with purposefully. These experiences were relatable, personal, or learned in an intentional manner.

Empathy among interprofessional team members is a prerequisite to clinical empathy with patients. Empathy positively influenced outcomes for patients in medical and social realms. However, for maximum impact, team members must foster empathy for one another via respect for one another's role, learning from differences, and role modeling empathy as a value.

Genuine intent is vital to the empathy relationship. Intentional empathic actions could include cognitive mechanisms to build rapport, affective gestures to foster trust, and pursuing meaningful ways to communicate connectivity to patients intentionally. Grounded theory is both a method and an approach to analyzing data (Charmaz, 2006). In this case, the work was context specific, and the intent was to generate theoretical elements among participants (i.e., healthcare providers who experienced a similar process). The approach began with inductive logic, utilizing broad concepts, and moved to a comparative, interactive, iterative, and emergent approach. This theory had limited scope and explained a specific set of phenomena; it was middle range in nature with an integration of theory and empirical work (Charmaz, 2006).

I utilized the approach of taking a critical stance toward data, using extensive memo taking, and breaking data up into rich components for in depth meaning review (Auerbach & Silverstein, 2003). I generated evidence for midlevel theory development, resulting in the formation of the IP-IECC theory. I used the theory to explain team-based practices in the healthcare field.

Theoretical Narrative

The discovery from this grounded theory study was the construction of the IP-IECC. There were four theoretical constructs that framed this midlevel theory: Empathy as a team was valuable; empathy was not accidental; empathy among interprofessional team members was a prerequisite to clinical empathy with patients; and genuine intent was vital to the empathy relationship. Together, the constructs functioned in parallel and created the context specific theory IP-IECC, which included several elements: symbolic attributes, deep personal experiences create meaning, purposeful perspective taking, team behaviors influence clinical outcomes, empathy as a collaborative engagement, and empathic intent.

This study offered IP-IECC theory as an answer to the following question: How do interprofessional teams conceptualize empathy in their work with patients and families? A system of actual or notional agreement of common attributes of empathy among team members created an overlapping process with how members purposefully sought to take the perspective of their patients. Healthcare provision by teams had varying responsibilities; empathy was conceptualized as valuable, both individually and collectively, and it was shaped over time by personal experience and symbolic definitions that solidified its value.

To answer the question of how interprofessional teams operationalized empathy in their work with patients and families, IP-IECC theory offered an alignment to the additional constructs; team behaviors influenced clinical outcomes, and empathy was a collaborative engagement. Although empathy was a complex phenomenon, a key

component of empathy was for patients to feel their experiences were valid and relatable (Riess, 2017). When healthcare professionals working together formulated the ability to cognitively think about and "know" empathy, emotionally connect to the concept, and create collaborative ways to engage in empathic behaviors, they could see tangible improvements in health.

The experience of demonstrating empathic approaches as a team could provide common threads that increase their cohesiveness. Examples of this included case conferences, intentional self and group reflection on patient cases, and acknowledging empathy as a joint team responsibility. Empathy could be embodied as a collaborative process not only with patients but also with and for each other; in fact, cohesion was strengthened by decisive approaches to reflect on perspective taking together, such as care planning as a team and role modeling empathy in practice.

Finally, the overarching theme of genuine intent as a component of the IP-IECC theory offered the consideration that empathy was not accidental. Empathy was an intentional process of engagement; therefore, it could be an act of cognitive engagement or emotional resonance. This theory positioned that while empathy could be taught, role modeled, and adapted as a skill, a genuine foundational basis was required. The empathic intent could originate from the desire to help, such as a feeling of compassion, care, or relatability. Genuine intent could be enabled from exposure to deeply meaningful experiences. IP-IECC was aligned to the notion that teams could bring about and foster mechanisms for understanding how intentional empathy centered care could improve

health outcomes for patients; ultimately, collective empathy in team-based care had the dual ability to increase cohesion and enhance healthcare.

Evidence of Trustworthiness and Credibility

Throughout this study, I ensured qualitative rigor by following the research protocol noted in the study proposal and also in the IRB application. Trustworthiness was upheld by implementing document management practices, recognizing bias through consistent use of memos, collecting data via focus groups and individual interviews, and using a careful member checking process that involved emailing the emerging themes to focus group participants as a group and each individual participant. Feedback from participants was incorporated in data analysis.

I chose to utilize memos as a procedural and analytical strategy throughout this study. As ideas began to form, I employed memo writing to capture bias, reflections, and prompt inquiry. One of the contextual factors in conducting this research involved trying to decide on an appropriate starting point for a large number of transcripts; therefore, the data were not always amenable to analysis without the use of memos to capture insights early in the process.

Transferability, Dependability, and Confirmability

In this qualitative inquiry, I created detailed ways in working with the data, organizing these data, synthesizing data, breaking these down, and seeking patterns for discovery. These detailed descriptions provided a basis for developing the theoretical narrative and the ways in which I represented participant voices. To preserve individual meaning, voice, and accuracy, I used NVivo software to organize the data. Depth and

breadth of the participant interviews was shared in detailed quotes, with evidence provided throughout this chapter.

I acknowledged dependability by working closely with my research chair and committee, as well as returning frequently to the literature and data. I sought to verify that findings were consistent with the raw data by following a step-by-step protocol. I shared coding samples with my chair during the initial phases of coding and returned to the member checks I completed. Because dependability required consistency and replication of the study, I followed a stepwise approach and provided a detailed description in my methodology. Finally, to achieve confirmability, I followed an audit trail and provided an in-depth description of this study, as outlined in my research proposal and IRB approval. I returned frequently to relevant text to verify findings were shaped by the participants, more so than by myself as a researcher.

Summary

In this chapter, I provided an overview of the setting for the research study, ethical consideration, demographics, as well as analysis techniques. In addition, I provided relevant evidence to support answering the questions of conceptualization and operationalization of empathy which built the foundation for theory generation also discussed in this chapter. I presented results, evidence of trustworthiness, credibility, transferability, dependability, and confirmability.

In summary IP-IECC theory was comprised of four main constructs that functioned in parallel via the following elements:

1. Empathy as a team is valuable: Symbolic attributes

2. Empathy is not accidental: Deep personal experiences create meaning, and purposeful perspective taking
3. Empathy among interprofessional team members is a prerequisite to clinical empathy with patients: Team behaviors influence clinical outcomes, and empathy as a collaborative engagement
4. Genuine intent is vital to the empathy relationship: Empathic intent

In the next chapter, I present my interpretation of the findings through a discussion, recommendations, conclusions, and reflections.

Chapter 5: Discussion, Conclusions, and Recommendations

Implications and Recommendations

The purpose of this qualitative grounded theory study was to discover and build a significant theory to explain empathy with patients and families in interprofessional healthcare teams. Specifically, I sought to understand how the conceptualization and operationalization of empathy in interprofessional teams translated to clinical practice. If empathy was not accidental and could be ascertained as a clinical competency, it could be embedded in the provision of care using intentional empathic activities.

Interprofessional collaborative practice is marked by high quality care delivered by varying professionals (WHO, 2010). Intentional empathy-centered care has the ability to adequately raise the expectations of indicators to measure quality. The WHO (2010) supported education that was interprofessional in nature and occurring when professions learned about, from, and with each other to improve client health. IP-IECC provided a basis for the inclusion of interprofessional demonstration of empathy in healthcare settings.

Findings in this study extended the literature in several significant ways:

1. IP-IECC was a grounded theory that explained why and how interprofessional teams could use distinct and intentional approaches to acknowledge, advance, and adopt empathy-centered approaches to improve health outcomes.
2. This study's results affirmed that empathy was not accidental, and while empathy could be taught, role modeled, and adapted as a skill, a genuine foundational basis was required.

3. This study offered that if empathic intent could originate from the desire to help, a feeling of compassion and care, or something relatable, then deeply personal and meaningful experiences should be acknowledged as reflective learning practices.
4. This study's results supported the premise that empathy among the interprofessional team should be discussed, honored, and cultivated. This process should take the form of empathy among team members and as a collaborative team engagement to benefit patients.
5. Although this study was exploratory in nature, it denoted that empathy was a clinical skill that should be known as an expected competency in healthcare. Future researchers should consider whether this competency could be screened, particularly concerning the formation of healthcare teams.

This research supported previous work about caring and emotional intelligence. Hawke-Eder (2017) noted how emotional intelligence was often taught by experiential learning, which could be clinical life experiences. These experiences involved powerful feelings, reflection, self-awareness, and aptitude. The concepts were explored in teaching nursing students, but caring was not simply defined, and there was no singular or unifying definition (Hawke-Eder, 2017). Findings from this study validated perspective taking and "walking in patients' shoes" as important elements of empathy. These findings were consistent with Kiosses et al. (2016), who noted three factors in the construct of empathy including perspective taking, compassionate care, and "standing in the patients' shoes."

Teams have increasingly faced complex healthcare factors bound by economic and social factors; at times, empathy has seemed overlooked in the current environment. The concept of caring or what constitutes good nursing has been queried (Hawke-Eder, 2017). Many healthcare professions set out standards to outline notions of caring and dignity as part of standards of practice, including social work (Battaglia, 2016). Underpinnings of these standards include respect, trust, and humanity. Hence, these standards have a place for how practice should be guided or provided. Patients who have been asked about qualities in their therapists that helped noted caring behaviors (Battaglia, 2016). Salazar (2013) noted educators have a responsibility to promote humanism through pedagogy, discourse, and relevant practice, which included building emotional, social, and academic skills.

Another concept was the educator's responsibility for promoting humanism through pedagogical principles and practices. The most relevant for this discussion was the educator's ability to build trusting and caring relationships with students. Findings from this study support the need for validation and rapport as essential for trust building and patient-centered care. Freire (2005) considered teaching humanism and noted educators must have a clear ethical and political alignment to change, particularly in oppressive situations (Salazar, 2013). Educators must (a) listen to students' interests, needs, and concerns; (b) know students on a personal level; (c) attempt to understand their life experiences; (d) model kindness, patience, and respect; (e) tend to students' emotional, social, and academic needs; (f) create a support network for students; (g)

allow for risk taking and active involvement; and (h) facilitate students' connection with their communities (Salazar, 2013).

Jeffrey and Downie (2016) considered empathy and the approach to teaching empathy. They noted it was difficult to define; however, empathy implied a degree of insight into what a patient was thinking or even feeling. This work supports the notion that empathy cannot be easily labelled. However, perspective taking and "walking in a patient's shoes" are important in conceptualization. Consistent with the findings of this study, Jeffrey and Downie (2016) linked empathy to a form of emotional intelligence and debated whether it was a skill or quality, and if it could be taught. Findings from this study pointed to a desire and interest from healthcare providers to embrace experiential learning on the basis that empathy had some innate characteristics.

Jeffrey and Downie (2016) signified that on many levels, empathy could be taught through behavioral, moral, affective, and cognitive dimensions; in fact, even though empathy had many definitions, a review of 10 rigorous studies showed it could be enhanced through physician teaching (Kelm, Womer, Walter, & Feudtner, 2014). Similarly, healthcare providers in this study noted teaching of empathy could be cultivated through experiential mechanisms directly linked to intellectual, interactive, and emotional features. Riess (2017) relayed that empathy as a capacity required taking in the perspective of others, and because of an interchange with varying neural networks, empathy could in fact be taught. Similarly, cognitive empathy as a targeted communication skill for training revealed a positive trend via JSPE scores as outlined by Batt-Rawden et al. (2013).

This study supports previous findings that acknowledge the importance of ensuring professionals practice empathy (Ross & Watling, 2017; Zaleski, 2016). However, there still remains the challenge of how to enhance empathy as a distinct skill. For example, bodies that govern social work often name empathy as a valuable care standard but have still paid limited attention to training specifically for empathy. Similarly, this study supported empathy as a value but with a lack of concrete mechanisms to foster it.

After a systematic review to look for quantitatively assessed changes in empathy due to interventions in physicians, residents, and medical students, Kelm et al. (2014) found that although literature was limited, empathy was important. Moreover, there was evidence that empathy could be enhanced. While the findings of my study did not include physicians, there was some congruency in how participants identified empathy and its effect on clinical outcomes. These comparative outcomes included higher patient satisfaction, adherence to treatment, improved clinical outcomes, reduced cost to the hospital system, as well as influence on clinician job satisfaction.

This study did not specifically look at the complexity or levels of care provided to patient populations by participants. Further extensions to this study could consider how inpatient or outpatient care settings influences the intentional aspects of empathic care. In addition, the ways in which empathy centered care is influenced by the level of complexity of a patient can be more intensely investigated as a means to enhance discourse on compassion fatigue and burnout in team based care.

If empathy was supported in the literature as having the ability to be taught to homogenous learners and professional groups, the findings in this study could further support the intentional aspects of teaching. Kiosses et al. (2016) confirmed empathy can be influenced by educational experiences. Future researchers can stratify the population further to consider conceptualization and operationalization of empathy as a comparison by discipline or team.

Few theories link learning methodologies to empathy specifically. The application of this theory can be included in research studies that screen and recruit based on key skills sets with empathy as an important attribute. Furthermore, the ways in which empathy can be taught are transformational. Traditionally, communication styles have been strongly supported by role play and didactic lectures, IP-IECC suggests an awareness of empathy can be acknowledged as a personal reflection. If deep personal experiences create meaning, then creating safety for their deliberate expression is important.

IP-IECC asserts that there are potentially innate features to the practice of empathy through the acknowledgment of genuine intent. Even so, its practice is not accidental. With this understanding, a team can cultivate the ways in which empathy can be discussed and intentionally harvested as valuable. Interprofessional teams who are presented with the opportunity to understand their relationships with one another, and with their patients in new ways can add to a positive patient experience. Purposeful perspective taking should involve empathically understanding an individual's whole

system and determinants of health while being respectful that it is impossible to entirely adopt another's perspective or lived experience.

Conversations surrounding empathy have the opportunity to shift focus to not only name it as valuable but also to teach it differently. To learn about empathy through personal reflection as a team in an intentional manner can cultivate common attributes, enhanced perspective, and intentional team approaches. Thus, a new way of teaching empathy in an interprofessional setting emerges: first, to focus on understanding common and agreeable symbolic attributes; second, to cultivate opportunity to reflect on individual and personal meaning as well as the role of perspective taking; third, to purposely build trust and rapport amongst team members; and fourth, to demonstrate empathy intentionally as a team. Curriculum designed to address this through case based discussions, patient engagement, simulation, or reflective practice should also acknowledge empathy amongst team members. Adamson, Loomis, Cadell, and Verweel (2018) note the significance of interprofessional empathy in a four stage model that suggests that developed awareness of differing frameworks builds collaborative practice.

The findings of this study support IPE and interprofessional practice, especially since they have been found to be important in assisting providers to work together for enhancing benefits to patients. The discovery from this work includes empathy as valuable in clinical practice for enhancing outcomes. However, an additional factor is the distinction of empathy as a collaborative practice with intentional team behaviors. The implications from this study suggest there is room to name empathy as a core competency to be recognized by IPEC and the CIHC. Two of four IPEC core competencies

underscore the importance of interprofessional communication and teamwork (IPEC, 2016). Communication includes patients, families, and professionals in a responsive manner. Teamwork is about applying relationship-building values for maximum performance (IPEC, 2016). This was supported by findings in this research study, including collaborative empathic engagement as a team and team behaviors that influence clinical outcomes. If collaborative engagement as a means to empathy practice could be nested in principles of team dynamics, its value as a core skill could be explicitly stated. Likewise, team behaviors such as interprofessional communication could promote empathy among team members with the goal of enhanced empathic care for patients and families.

In Canada, the CIHC framework shares best practices and knowledge in IPE and collaborative practice (CIHC, 2010). Two of six competencies specifically address interprofessional communication and patient centered care as a means to support the other domains. This research supports the notion that the ways in which interprofessionals communicate with each other need to be responsive and collaborative. Patient-centered care values input and engagement in designing care. The findings from this study recognize the role of empathy in interprofessional communication and comprehensive patient engagement. Application of the theory of IP-IECC in the context of interprofessional teams can advance how teams could use distinct and intentional approaches to acknowledge, advance, and adopt empathy-centered approaches to improve health outcomes.

This context-specific work contributes to bodies of literature that support drivers for patient-centered care and IPE. Patient-centered care has been linked to better health outcomes and improved patient satisfaction (Hojat et al., 2015). Empathy has been noted as desirable and has correlated with patient satisfaction and time savings (Ross & Watling, 2017). Findings from this work support this and further build on the opportunity to facilitate patient-centered teaching and learning, specifically intentional empathy-centered care.

The findings of this study also support expanded exploration of how teams can engage in a personal and professional conversation about their own relationships to empathy. Developing an understanding about the utility of empathy in team practice should include exploration of the complexity of social team dynamics and system supports. The implications of this work include the opportunity for the theme of empathy in healthcare provider-patient relationships to be revisited. The proposition that patients benefit when members of a team provide empathic care together is supported by this work. Overall, the findings suggest the value of empathy in a team can be cultivated and intentionally fostered.

Despite the growth of IPE, there have been few theories developed to guide interprofessional practice in healthcare. The findings of this work narrow the gap for this by introducing IP-IECC as a guiding framework to explain empathy and its relationship to interprofessional teams. The space in which empathy can be interpreted, valued, and demonstrated can be complementary to interprofessional teaching about intentional practice.

Limitations

The findings of this study were based on a context specific sample of participants from various disciplines who worked together in healthcare settings serving the same population. While the conclusions and constructs were based on this small homogenous sample (n = 24), the individuals were subject matter experts not only in their professional backgrounds but also in their areas of practice. Even though the sample was small, the purpose of this work was to develop context specific theory using a grounded theory approach. Therefore, the intent was to develop a foundation for future research. The study design could be applied to other healthcare settings, such as community health centers, community based primary care teams, and wellness based clinics. In addition, the study is applicable to varying of professionals, such as personal support workers, team assistants, peer workers, and administrative leaders.

A further limitation of the study was specific to the disciplines enrolled, I did not control for the type or number of healthcare backgrounds participating so long as they were varied. Many of the professions enrolled have been historically drawn to the non-medicalized aspects of healthcare such as caring. To this end, the study was open to physician participation; however, none enrolled in the study. In many settings, physicians are the decision makers regarding care delivery; the findings of this study may have illustrated alternate viewpoints with the inclusion of physicians in data collection. Issues such as decision-making, power differences, expected roles, and communication may have been further explained or explored for. Future studies could intentionally recruit for physician participation as a means to explore concepts of empathy.

Another potential limitation of this study was the use of the word empathy as previously understood by participants to some extent; future research could verify historical understanding of the word in healthcare or provide a working definition. Additionally, I did not specifically recruit for healthcare teams who were newly formed or self-identifying as requiring team building; therefore, I could not decipher the influence of the types of teams who volunteered.

Positive Social Change

I sought to first understand the problem, and then to represent participant voices in the primary findings from his study. This study was designed with the goal of advancing social change in mind. The findings from this work would impact social change by applying identified learnings to how the practice of empathy integrated into IPE and healthcare delivery.

I intended to disseminate study findings to the research community, particularly to formal bodies that advanced research and education in IPE. The context specific theory could also provide insights to generate practice discussions in community and acute care settings; to this end, findings should be shared at hospital specific conferences and teachings.

Because health provision had moved toward increasingly significant team based care, I hope to connect with community partners who influence health outcomes in the community support service sector including mental health and additions. I hope that the findings from this research study can influence interprofessional team practice outside of hospitals, particularly as health is inclusive of social determinants of health.

Reflections of the Researcher

Understanding the role of empathy in healthcare has always been important for my own clinical practice; therefore, discovering the opportunity to explore this through a grounded study research design kindled a natural passion for me. The participants shared deep reflections about their patient interactions, growth as a team, and own personal experiences and stories. Therefore, this afforded me the opportunity to listen and present the voices as a researcher; at times, this process was filled with connectivity, relatability, and emotional appreciation.

Through this research, I learned that empathy could not always be grasped in a singular way; as one participant said, "You have to understand your own set of values," and another reminded me that "empathy can be taking a look at the world from the patient perspective." In more than one interview, I learned of the intricacies of empathy in practice, such as "honoring the patient," and "I pick up on small subtle cues…if a patient is cold, I remember they always have a sweater on and make sure they get a blanket." At times, it can be simple and sweet, such as "how are you feeling today?"

One participant reminded me that empathy came in all forms of practice, such as setting treatment goals through play "if a patient is capable of setting their own goals, that's ideal because then its more intrinsically motivating for them." Empathy could also come by building trust; for example, one participant noted, "It's really trying to get a sense of what is happening for the patient, what they're experiencing, what they are feeling, and to find a piece of that you can identify with and then reflect back to the patient." Empathy could be fostered through caring actions, such as "learning the names

of their food in their language." It could grow out of sincere statements, such as "we'll take you as you come," and someone who simply said, "Empathy can be, you just hold their hand." Another participant stated, "Just be open and kind and nice and understand their viewpoint."

Empathy could be shared among team members in their care; for example, "the more of you that have an understanding and share that same compassion and that approach and that empathy and awareness of what it means, I think that then your whole unit flourishes." Another participant said, "It helps to look at things holistically." Teams who work consistently together offered great insight about the natural aspects of empathy, such as "I think it's a purposeful thing. I think it's a purposeful activity," and the importance of "creating an open environment to share."

During this research, I remembered how clinical practice could be linked to empathic actions, such as one participant who noted it was important to "to be present in that interview with that person. So, I think physically breathing, calming oneself down, being prepared, but also knowing what it is that the person brings." Another shared, "If you are being empathetic, you can see it in their eyes. You can see it in their expression. You're connected."

Several participants reminded me that empathy could go beyond the patient: "It always involves engaging the family," and a reminder that "better empathy equals better care." I was inspired by the number of participants who remarked at the ease of empathy in their world, such as "it just happens, its natural," and "I think if you work with other team members that have a good sense of empathy, I think it rubs off."

Participants shared their early experiences nursing in other countries, the value of connecting with their community, and the ways in which they learned from the loving relationships with grandparents. These participants reminded me that this "shaped my care," and they acknowledged that empathy was an "emotional connection and maybe intuition too." They also shared "sometimes it can evoke an emotional response," and I recognized that for some it meant the following: "Life experience taught me the value of empathy." Therefore, I am grateful for the rich voices that are now part of my own empathy experience; as one participant said, "I cannot imagine practicing without empathy."

Summary

This chapter offered an overview of implications for social change and future research of the theoretical narrative of the IP-IECC to answer how interprofessional teams conceptualized and operationalized empathy in their work with patients and families. The IP-IECC was based on two conceptual frameworks: Barrett-Lennard's (1985) cyclical phases of empathy and Ajzen's (1991) TPB. I showed the extended impacts of this work in creating IPE and building effective healthcare teams. In addition, this chapter showed the positive benefits of empathy centered care and bodies of literature that sought to advance empathy practice in healthcare settings to center team-based care that was quality focused and patient centered.

Conclusion

Interprofessional work requires a level of collaboration and support particular to the interactions with each other and patients; these teams are intentionally created to

share accountability for care (Ketcherside et al., 2017). The provision of this care is influenced by interactions of perspective taking, deep personal experience, and team behaviors that support empathy as a key clinical competency. Empathy is important not only to the patient-provider relationship but also between healthcare team members; empathy improves interactions between team members. Hence, empathy should inspire discourse about the ways in which teams can intentionally innovate, cultivate, and foster empathy-centered care as part of interprofessional team practice.

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Appendix A: Demographic Screening Questionnaire

How interprofessional teams conceptualize and operationalize empathy in their work with patients and families in a healthcare setting

Identifier Code:_____ Date: _____

The purpose of this form is to screen potential participants to ensure they meet the criteria for the study.

This research is designed to minimize the risk to human subjects. The study is designed to focus on individuals who are suited to answer the study's research question. I would like to ask you a few questions to determine if you are best fit to participate in helping to answer the research questions through the interview process.

To be read to the Participant:

1. To participate, you must be 18 years of age or older and English speaking.
2. To participate, you must be working in an inpatient or outpatient healthcare setting.
3. To participate, you must be a member of an interprofessional team made of varying disciplines serving the same population in a healthcare setting.
4. To participate, you must have been working on the team for at least 6 months.
5. To participate, at least 3 members of your team (including yourself) must participate in a 60-minute focus group with each other.
6. To participate, you must be willing to also participate in a 60 minute face to face interview with myself

You cannot participate (exclusion criteria): You are a student, client, or previous employee or team member of the researcher.

If you qualify to take part in this study and would like to voluntarily participate, I will schedule our interview. Prior to the day of the interview, I will further inform you of the study by sending you a form known as informed consent.

Appendix B: Individual Semistructured Interview Guide

To the Participant: Thank you for your participation today. This research is about you and your experiences related to empathy with patients and families. Please do not use any specific details or names related to patients, families or colleagues. This interview will be audio recorded and I will also take notes. You can skip a question or stop the interview at any time.

Are you okay to proceed with the interview?

We are here to talk about some of your experiences of empathy in your work.

a) Please describe your role on the team?

b) Please tell me about your patient population?

c) How do you perceive your role on the team?

d) How would you define empathy?

e) Tell me about the thoughts and feelings that you associate with empathy?

f) Tell me about any bad things associated with empathy?

g) Tell me why it is or is not important that you practice or have empathy in your work?

h) Can you tell me about some of the ways in which you have either been taught about or learned about empathy?

    a. Probe: have you received any formal or informal training in empathy as a skill?

i) Health science researchers have indicated that empathy can improve clinical outcomes, what do you think about this?

j) What are some of the ways in which empathy can be conveyed to your patients and families?
    a. Probe: Can you give me an example?
k) What do you do to maintain awareness of empathy for yourself?
l) What do you do to maintain awareness of empathy as a team?
m) Can you tell me about your intentions to use empathy in your work with patients and families? What do you see as the value of empathy in your practice?
n) What makes it easy or difficult to practice empathy?
o) Do you notice any similarities or differences in empathic practice among your fellow team members?

Appendix C: Focus Group Questions Guide

To the Participants: Thank you for your participation today. This research is about you and your experiences related to empathy with patients and families. Please do not use any specific details or names related to patients, families or colleagues. Do I still have your permission to audio recorded and take notes?

Are you okay to proceed with the interview?

We are here to talk about some of your experiences of empathy in your work.

a) Tell me about your role on the team
b) Tell me about your patient population and your team approach
c) Tell me about why it is or is not important to use empathy in your work
d) Tell me about your intentions to maintain awareness of empathy as a team
e) What makes it easy or difficult to use empathy in a team environment?
f) What do you see as attributes and thoughts associated with empathy?
g) Tell me about examples of empathy in your work with patients and families either that you have engaged in yourself or notice your team members engaging in?

Appendix D: Categories, Codes, Relevant Text, Theoretical Framework

Table G1

Categories, Codes, Relevant Text, Theoretical Framework

Categories	Codes		Relevant text example	Theoretical framework
Teamwork	• Length of time working together • Anticipate and meet needs • Vulnerable populations • Case conferences-frequency • Negotiating care • Partner with patient • Respect different roles • Respect different views • Positive reinforcement • Personal experiences • Supportive leadership • Whole person care	• Listen • Empathy with each other • Empathy perspective as value • Role modeling • Demonstrating • Shadowing • Joint care • Care planning • Care about each other • Working through conflict • Rounding	"We round after a day of clinic and you hear each clinician's view of that patient or what they learned in that visit"	TPB- attitude and perceived control
Experience	• Creative approach • Interviewing skills • Motivational interviewing • Addressing basic needs • Non-judgmental • Mother teaching • Canvassing at young age • Different countries • Life experience • Grandparents • Witnessing poverty	• Starting with small goals • Grows with time • Meditation • Mindfulness • Openness • Volunteer work • Humanitarian work • Addressing stereotypes of professions • Caregiving • Meaningful moments	"the way that I approach empathy came before I was a professional and I would ultimately say it was my mother"	TPB- social norms

(table continues)

Categories	Codes		Relevant text example	Theoretical framework
Learning	• Continuous process • Learning from practice • Authentic patients • By example • Organizational support • Simulation • Self-reflection • Recording sessions	• Didactic • Active listening • Accountability • Role model • Life experiences • Observation • Flexibility	"I think that you can almost get better at empathizing as you have more experience"	Barrett-Lennard – empathic set, resonance
Clinical Outcomes	• Connection • Respect • Communication • Compassion • Sympathy • Intention • Culture • Goal setting • Embedding	• Patient centered • Educating patients • Patient satisfaction • Job satisfaction • Family engagement • Importance of relationship building • Patience • Work together	"I've seen it over the years with patients, because you're creating the safe environment that's nonjudgmental and experiencing their experiences for the moment of the session and then they feel comfortable and they're really able to increase compliance"	TBP- intent Barrett-Lennard- listening, validation
Intention	• Self-expectations • Addressing bias • Morals • Values • Problem solving • Evolves from kindness • Body language • Personal choice • Standards • Behaviors	• Knowing when to be intentional • Goal setting • Understand their experiences • Genuine • Be present • Intuition • Cognitive	"I think it's preparing in many ways. So preparing physically, and preparing cognitively"	TPB- intent, behaviors

(table continues)

Categories	Codes		Relevant text example	Theoretical framework
Attributes	• Different than sympathy • Anticipate • Neurological mimicking • Listening • Compassion • Focus on strengths • Gentle • Support	• Communication • Understand • Sensitivity • Validating • Supporting • Trust • Rapport • Relating • Gestures • Advocate	"being sensitive even to somebody's body language or energy"	
Defined	• Point of view • Perspective • Engaged detachment • Borrowing feelings • Human Connection • Building a relationship	• Connectivity • Walking in their shoes • Imagine yourself in world • Honoring	"I think empathy really is the ability to kind of put yourself in somebody else's shoes for a little bit and taking a look at the world from, from their perspective"	
Importance	• Positivity • Creative solutions • Patient centered • Helps hospital indicators • Rapport • Patient history	• Respect • Encouragement • Culture • Motivation level • Empowerment • Valuable • Holistic	"I think empathy is a beautiful thing"	
Barriers	• Takes time • Acknowledgement as a value • Busy unit • Volume and capacity • Challenging interactions • Personal challenges • Burnout	• Balancing with risky behavior • Varying values on team • Lack of understanding • Lack of experience • Transference • Compassion fatigue	"I think what makes that a little bit harder is you can get a little bit burnt out and sometimes end up carrying that a little bit more"	

Appendix E: Repeating Ideas and Themes

Table E1

Repeating Ideas and Themes

	Attributes	Experience	Importance
Empathy as team is valuable	• non-verbal • non-judgmental • supportive • caring • compassionate • "walking in their shoes" • "taking the perspective of others" • patience • "borrowing another's experiences"	• evolves over time • create a physical and emotional space at work • Empathy can be seen • Empathy is associated with positive behaviors • Empathy can be felt	• humanity • learn the non-medicine parts of patients
Empathy is not accidental	• empathy has many innate qualities • healthcare attracts empathic attributes • families can foster empathy early	• aligned to a set of individual values • core beliefs influential • early childhood experiences shape the evolution	• learning is more than didactic • opportunity to reflect and grow can be sought • seek meaningful moments • clients teach us about empathy
Empathy among interprofessional team members is a prerequisite to clinical empathy with patients	• plan for care together • interweave strengths • address differences • respect roles	• learning together can improve clinical outcomes • collective team practice of empathy fosters personal and professional support	• job satisfaction • patient satisfaction • patient adherence • supportive leadership • empathy should be linked to accountability
Genuine intent is vital to the empathy relationship	• connectivity cannot be faked • thoughtfulness is a cognitive and emotional process • trust building is intentional	• learning can be sought • empathy is relational	• value culture, individual choice and motivating factors for patients